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CONSOLIDATION IN THE PENNSYLVANIA HEALTH INSURANCE INDUSTRY: THE RIGHT PRESCRIPTION?

HEARING

BEFORE THE

SUBCOMMITTEE ON ANTITRUST,
COMPETITION POLICY AND CONSUMER RIGHTS

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

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CONSOLIDATION IN THE PENNSYLVANIA HEALTH INSURANCE INDUSTRY: THE RIGHT PRESCRIPTION?

THURSDAY, JULY 31, 2008

U.S. SENATE,
SUBCOMMITTEE ON ANTITRUST, COMPETITION POLICY AND CONSUMER RIGHTS,
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:17 p.m., in room SD–226, Dirksen Senate Office Building, Hon. Herb Kohl, Chairman of the Subcommittee, presiding.

Present: Senators Kohl and Specter.

OPENING STATEMENT OF HON. HERB KOHL, A U.S. SENATOR FROM THE STATE OF WISCONSIN

Chairman KOHL. Good afternoon to one and all. Today we will be examining the consolidation in the health insurance market with the proposed merger of the two largest health insurers in Pennsylvania—Highmark and Independence Blue Cross. We are holding this hearing at the specific request of my colleague for whom I have the very highest regard, Senator Arlen Specter. As this merger most directly impacts Pennsylvania residents, I have asked him to preside over today's hearing, and he will.

After the merger, these two insurers' combined market share in Pennsylvania is estimated to be more than 70 percent. Allowing a single health insurer to gain such a high market share in Pennsylvania obviously raises significant competition concerns for the citizens of that Commonwealth, especially since these two companies apparently agreed not to compete a year ago.

But it is also important that we consider competition in health insurance across the country. As health insurance costs continue to rise, consumers face ever increasing premiums. At the same time, we hear complaints from physicians and hospitals of declining reimbursements and take-it-or-leave-it contracts that negatively affect patient care. New competitors face high barriers to entry, so allowing high levels of concentration can have serious and lasting effects for many years to come as the stats point to substantial evidence of rising consolidation in an already high concentrated health insurance market.

In 299 of the 313 metropolitan areas studied by the American Medical Association last year, health insurance was a highly concentrated insurance under Justice Department guidelines. The

number of health insurers nationwide has fallen by 20 percent since the year 2000, and this has clearly contributed to rising insurance rates. The AMA study found insurance rates were 12 percent lower in States with more competitive choices.

The burden of ever rising insurance rates is borne particularly heavily by small businesses who find it increasingly difficult to offer health insurance for their own employees. And the problem of increasing concentration is compounded by the failure of the Justice Department to enforce the antitrust law in this insurance.

According to the 2007 AMA study, in the last 12 years, out of 400 health insurance mergers, the Justice Department challenged only two. Vigorous competition in health insurance is essential to lowering health insurance premiums for consumers, for businesses, and to assuring adequate payments to health care providers.

We on the Antitrust Subcommittee will pay close attention to competition in health insurance markets in the months ahead. We will consider holding hearings on health insurance competition at the national level. We plan to ask the GAO to study the impact of consolidation on rising health insurance prices.

For all these reasons, today's hearing is a particularly relevant one for our Subcommittee, and I thank Senator Specter for his work on this very important issue. And so we now turn the gavel over to Senator Arlen Specter to preside at this hearing.

Senator Specter.

STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. [Presiding.] Well, thank you very much, Mr. Chairman. I appreciate the outstanding work you have done on the Antitrust Subcommittee of Judiciary and the outstanding work you have done as the senior Senator from Wisconsin now for 20 years. It has been quite a responsibility, and you and I have worked together generally and on the Judiciary Committee, and this is a very important hearing, and I very much appreciate your authorizing it and turning the gavel over to me.

Last year, I was Chairman of the Committee. I was about to say I "owned the gavel," but you do not own anything in the U.S. Senate. It is all leased, 6 years at a time. And now I have it for part of the afternoon. So it is nice to have, and I will use it sparingly, and I hope effectively.

As Senator Kohl has outlined, this is a very important hearing. The issue of health care in America is a dominant factor. Estimates nationally run as high as $1.7 trillion in health care expenses, and we have a situation where it is estimated that some 47 million Americans do not have health insurance. And no one knows better than I about the importance of good health.

As you can tell, a Pennsylvania cable network is carrying this. People within the room can see it better, how pale and bald and thin I am compared to the way I used to be. I am just finished a bout of chemotherapy for Hodgkin's, and my slogan is: "It is tough, but tolerable." But it is a rugged process. And I have had more comments about my hair style than I have about my positions on public policy. I have had some suggestions that I should wear a

toupee, and I have rejected that. Some people say I should shave my head and become a sex symbol like Joe Frick or Henry Miller.

[Laughter.]

Senator SPECTER. And I have rejected that also on the ground that—two grounds: number 1, my wife is opposed to it; and, number 2, I am not qualified. So I will let nature take its course. I was very deferential to Senator Kohl in not bringing him into Mr. Frick and Dr. Miller's categories here.

But in a very, very serious vein, it is a major matter. I note that the Department of Justice has given approval to the merger. I know that it is under consideration by the Insurance Department in Pennsylvania. And Congress has a keen interest with the Judiciary Committee and the Antitrust Subcommittee.

We are aware of the considerations of economies which have been represented about what can be saved if there is a merger of Highmark and Independence Blue Cross. We are concerned at the same time about the market share. The projection has been made that Independence Blue Cross has about 30 percent of the market in the East, principally, and the estimate as to Highmark ranges from 27 to 42 percent of the market, so that competitors have a hill to climb, and perhaps a steep hill, and we will talk about that.

Some of the competitors in the West have thought that the combination between UPMC and Highmark made it difficult for entry, and UPMC has taken a position in opposition. I have been interested to see that Temple University Medical System and the University of Pennsylvania have not taken a position. The Hospital Association has and the doctors' associations have. So there are a lot of competing interests.

We had a hearing on this matter in Philadelphia last year, and we thought it would be a good idea to convene another hearing and to explore these very important issues.

Senator Casey could not make the hearing today. He has been invited to attend, and I know he will be following it very closely because it is a big, big matter for Pennsylvania.

You see the lights we have here. Green means you are within the first 4 minutes, and yellow means you are within the last minute; and when the red sign goes on, it means you are supposed to stop talking. We have a big panel today, and we had started with six witnesses, and I wanted to add two more besides Dr. Melani and Mr. Frick, who were in favor of the merger, to have a balanced presentation.

So with my red light about to go on, 5 seconds left, I would ask all of you to stand and raise your right hands. Do you affirm or swear that the testimony you are about to give before this Committee, this Subcommittee, will be the truth, the whole truth, and nothing but the truth, so help you God?

Dr. MELANI. I do.

Mr. FRICK. I do.

Ms. SCANLAN. I do.

Mr. MARSHALL. I do.

Mr. LAIGN. I do.

Mr. BALTO. I do.

Mr. ALLEN. I do.

Mr. HARRIS. I do.

Senator SPECTER. May the record show that each of the witnesses has answers in the affirmative.

Our first witness today is Dr. Kenneth Melani, who is the Chief Executive Officer of Highmark. He began his career with the company in 1989 as a corporate medical director in the Medical Affairs Department, graduated summa cum laude from Washington and Jefferson College with a bachelor's degree in chemistry and biology, and received his M.D. from Wake Forest University.

Thank you for joining us today, Dr. Melani, and we look forward to your testimony.

STATEMENT OF KENNETH R. MELANI, M.D., PRESIDENT AND CHIEF EXECUTIVE OFFICER, HIGHMARK INC., PITTSBURGH, PENNSYLVANIA

Dr. MELANI. Thank you, Senator, and good afternoon. My name is Dr. Ken Melani, and I am the President and Chief Executive Officer of Highmark. With me is Joe Frick, the President and Chief Executive Officer of Independence Blue Cross. We want to thank the Committee for the opportunity to speak to you today about why the proposed combination of Highmark and Independence Blue Cross into a new company is good for Pennsylvania and how it will create value for the communities in which we operate, for our customers, for health care providers, and, most of all, for the people of Pennsylvania.

Since we spoke to the Senate Judiciary Committee in April 2007, we have been engaged in an extensive review process involving State and Federal regulatory agencies, with input from State and Federal public officials. This is an important, cooperative, and open process. Today, we continue this open dialog about how this combination will better serve the needs of the people of Pennsylvania.

Our companies have a proud tradition of serving Pennsylvania as not-for-profit companies. For 70 years, IBC and Highmark have had a common mission: to help ensure that health care is available, affordable, and of high quality for all Pennsylvanians.

Throughout our history, we have made health insurance programs available to everyone, regardless of age, gender, and health status. We have provided assistance to people in financial need, by subsidizing health insurance programs for children, lower-income individuals and families, and older adults. Moreover, we have provided financial support for health education and community health programs.

At the same time, according to a study performed by a market research firm, Tripp-Umbach, Highmark and IBC have had a significant, positive impact on Pennsylvania, with a total annual economic impact of $4.2 billion on the State's economy. The companies employ approximately 18,000 people in high-quality jobs in the State and purchase a significant amount of goods and services from Pennsylvania-based companies.

This transaction, however, is not about the past or the present. It is about the future and about preserving our nonprofit status. And it is about laying the foundation for positive change in the way health care is delivered and paid for in Pennsylvania. Coming together, our two companies can remain a financially vibrant Pennsylvania-based company and achieve tangible savings and growth

opportunities of more than $1 billion that will be used to address health care costs, quality, and access to medical care in Pennsylvania.

This combination will also allow us to strengthen our contribution to the Pennsylvania economy—by the way we employ people, by creating new businesses opportunities for Pennsylvania-based businesses, and by supporting the community through programs and services that we have historically embraced.

The proposed combination is important given the challenging health environment that exists today. Health care costs are rising dramatically. We know that the cost of health care is making health insurance less affordable for businesses today. As a result, fewer businesses are able to maintain health care coverage, and more people are going to the ranks of the uninsured. We are also seeing more people moving to public health insurance programs, which means more health care coverage is being financed through Federal and State government programs.

The demographics of Pennsylvania also present challenges. The State has an aging population that is creating more demand for health care services. We also have an aging workforce in many industries, including health care. This places an added strain on the health care system as the aging population uses more medical services. Questions are also being raised about the quality of health care today and the variation in medical care from community to community for people with the same medical conditions.

With these critical issues facing us across Pennsylvania and nationally, rapid change is occurring in health care. Consumers are taking a greater responsibility for their personal health care decisions and their costs. This change is creating the need for investments in technology so people can access their own personal health information and have programs available to better manage their own health.

As these forces shape health care, two points have become very critical to business success. First, scale has become increasingly important to achieve greater efficiency and lower administrative costs. The scale of competition has shifted from a local to a regional and now a national basis. We have a growing need to be a multi-product, multi-market company to compete in the future, to spread our risks, and to better serve our customers. Second, there is a growing need for capital for investments to meet the marketplace demands that I outlined earlier.

The health insurance industry is responding by consolidating. In the past 15 years, the top 20 insurers have substantially increased their share of subscribers in the commercial health insurance market. Even more significant, during the same period, large, well-capitalized for-profit insurers have gained a much larger share of commercial health insurance subscribers compared to not-for-profit health insurance companies.

The largest players in health care today are WellPoint, United HealthCare, Aetna, and CIGNA, and anywhere from 13 million up to 35 million subscribers reside in each of these companies. They have the scale, the product diversity, and the geographic diversity to spread their operating costs over more subscribers. They also can leverage their large subscriber base to obtain better pricing

from national suppliers of laboratory services, durable medical equipment, radiology services, and pharmaceuticals—in contrast to Highmark and IBC who have, combined, 8 million members.

Consolidation is not unique to the for-profit health insurance companies. It is happening in the Blue Cross/Blue Shield system in the United States as well.

Today, there are 39 independent Blue Cross and Blue Shield companies. That is a third the number since 1980, when there were 115 such companies. In fact, Blue Cross/Blue Shield companies operate in multiple States. These companies have gained operating efficiencies and can better serve their customers.

And Pennsylvania stands alone in that we have four independent Blue Cross/Blue Shield companies. It is problematic because we are operating less efficiently than we could be by investing in redundant technologies and capabilities that add more cost to the health care system.

As the two companies have looked at the changing health care environment and the need for greater scale and more capital, it has become clear that the combination of IBC and Highmark is a natural fit that would bring significant benefits to the people of Pennsylvania. The two companies have almost identical missions and have worked together for over 50 years to better serve the community, through programs like the Caring Foundation. We also have complementary products. Highmark's vision, dental, and stop loss lines of business complement IBC's pharmacy benefit management—

Senator SPECTER. Dr. Melani, how much longer will you require?

Dr. MELANI. About 30 seconds.

Senator SPECTER. Go ahead.

Dr. MELANI. Complement IBC's pharmacy benefit management, third-party administration, and workers' compensation programs. Together, our two companies can offer a core blend of products to better serve our customers on a common platform.

What is most important is that bringing our companies together will not lessen competition in the commercial health insurance market or reduce choice in any market in Pennsylvania in the future. Our subscribers will continue to have the same wide variety of choice from a competitive health insurance market as they have today.

Although over 100 witnesses appeared at the recent Pennsylvania Insurance Department hearings—and many others have filed comments with the Insurance Department—we are not aware that any of our over 50,000 commercial customers have complained that they will have less choice for insurance the day after the transaction than they have today.

And, last, as you both well know and have articulated, the United States Department of Justice has twice reviewed this transaction for consolidation of the two companies and both times cleared the transaction under the Federal antitrust laws.

I thank you very much. I am going to turn it over to Joe to talk about the benefits of the consolidation.

[The prepared statement of Dr. Melani appears as a submission for the record.]

Senator SPECTER. I am going to ask everybody who testifies to stay within the time limit. Nine witnesses and a question-and-answer session, which is very important, is going to run us very late. So please stay within the time limit.

Dr. Melani, I do not intend to pursue questions after each witness, but I have listened to your testimony, and some of the generalizations you have made might be relevant to a concern on my mind. But I do not hear you addressing the fundamental question as to whether this merger, which purports to have economies of scale, has the potential to lower the premiums for health insurance, it will cost less for people to buy health insurance. How about that? That is what the consumers are interested in. How much is it going to cost them? Did you address that in your opening statement?

Dr. MELANI. Senator, I did not get into the detail, but Joe has some of that in his comments.

Senator SPECTER. Never mind the detail. Is it going to result in lower cost to the consumer?

Dr. MELANI. It will result in lower administrative cost to the consumer. We are guaranteeing that we will fix our administrative fees flat for 2 years. The difficulty with the remaining part of health care costs is the variables; 90 percent of the health care costs are really in the provider side of the equation in units used and units paid, and it is very difficult to put a cap on what happens in the cost of health care on that side of the equation with so many unknown variables in that side. But the part we do control, which is administrative cost, we absolutely will guarantee a benefit in lower premium from that perspective.

Other things that we will do we hope will help with the other part of the health care cost equation, like investments in new technology, disease management, and other capabilities.

Senator SPECTER. Dr. Melani, candidly, I do not understand much of what you just said. Talking about variables, talking about administrative costs, I heard you say the administrative costs will be reduced and that will have an impact on premiums. Well, administrative costs are only one aspect of a very, very big picture. I would like to see you tell this Subcommittee—if not this afternoon, later—what is the impact going to be to the consumer. I am going to come to—I do not consider that a detail. But we will listen to what Mr. Frick has to say about it. But I think we need something a lot more specific on that point because that is the whole issue. The generalization of administrative costs being reduced and that being passed on to the consumer is not the big-ticket item.

We turn now to Mr. Joseph Frick, elected President and CEO of Independence Blue Cross in January of 2005, previously was Senior Vice President. Prior to joining IBC, he was Vice President of Human Resources at Philadelphia Newspapers, Inc.; received his undergraduate degree from the University of Notre Dame and an MBA from Loyola College.

The floor is yours, Mr. Frick, for 5 minutes.

STATEMENT OF JOSEPH A. FRICK, PRESIDENT AND CHIEF EXECUTIVE OFFICER, INDEPENDENCE BLUE CROSS, PHILADELPHIA, PENNSYLVANIA

Mr. FRICK. Thank you, Senator, and I appreciate the opportunity to be before the Committee as well. As Ken said, our two organization have a proud tradition of serving our subscribers and our local communities as Blue plans, and we know we have a responsibility to promote the value and enhance the trust of the Blue brand, which serves more than one in three Americans.

So while coming together is a logical extension of our historical partnership, we believe that the growth opportunities, the efficiencies, and the savings will enable us to achieve several real and important goals. And as you just articulated, first and foremost, we are committed to help make health insurance more affordable. It is the number 1 issue with our subscribers; we have a responsibility to do better on that issue.

At the same time that our subscribers are demanding that we control costs, they also want us to invest in products and in services to help improve quality and health and health care outcomes and expand our efforts in promotion and wellness programs.

Physicians, hospitals, and health care providers, who we pay 88 cents back for every dollar of premium that we take in from our customers, they are valued partners in our companies' mission of assuring access to high-quality networks of providers. And we are committed to maintaining these well-established relationships and enhancing incentives to ensure the delivery of high-quality care and keeping costs manageable.

We will continue to be a viable and successful leader in our communities, and we expect to generate new business, which can bring more jobs to Pennsylvania and stimulate additional business opportunities for Pennsylvania-based business.

Finally, we need to be more effective and use technology, and this combination will enable us to be a company that is easier for our subscribers and providers to do business with.

And by combining our two companies—and only by combining our two companies—will we be able to generate over $1 billion in additional economic benefits over 6 years. And this is new money beyond any commitments that our two companies have today.

These dollars will be generated by business efficiencies and growth opportunities that our companies could not produce individually. And unlike with consolidations of for-profit, publicly held companies, we pledge that every dollar of these economic benefits will go back to improving health care in Pennsylvania.

In addition to this $1 billion, we voluntarily agreed to extend the Community Health Reinvestment Agreement with the Commonwealth for an additional 3 years, an estimated $350 million that can be used to help more Pennsylvanians obtain health care coverage.

So for our subscribers, as Ken said, we pledge to freeze the administrative fees for 2 years. This represents $295 million in tangible savings.

With our new pharmacy business, we believe we can save another $285 million on prescription drug costs which goes directly back to our customers.

We expect that an estimated $100 million of the efficiencies will be used to fund expanded health care quality programs—ePrescribing, personal health records, electronic medical records. Use of these tools leads to higher-quality care, fewer medication errors, and that does result in greater savings to subscribers in the long run.

We will expand the best of the health promotion and wellness programs offered by our two companies, which will enable a healthier workforce to be more productive, consume fewer health services.

We are proud of our longstanding relationships with physicians, hospitals, and providers. The value of our brand is based on the fact that we offer our customers high-quality provider networks, and they will remain important partners with us in the future.

In the past few years, IBC and Highmark have invested in technology and pioneered a tool called NaviNet to simplify administrative transactions with physicians and hospitals. We will build on this capability so that physician offices and hospitals can spend more time to improve patient outcomes, patient safety, the health and wellness of their patients, and worry less about administrative tasks.

And here is one very important point about providers. Not one dollar of the $1 billion in net economic benefits will result in any reductions in provider reimbursements.

Over the past few years, Highmark and IBC have developed close working relationships with hospitals and physicians, partnerships focused on improving safety and reducing prescribing errors. The new company will expand these partnerships.

Last, let me talk about how the consolidation will benefit our local communities. Last year, our two companies committed over $200 million in programs in the community, funding clinics and nurse scholarships, programs to reduce childhood obesity. And the new company intends to take all of these initiatives statewide. So together these commitments total $1 billion in new money, plus $350 million, in the Community Health Reinvestment Agreement.

The consolidation is important for us to remain a viable, not-for-profit company to strengthen our commitment to the community and the economy of Pennsylvania. Do we expect to grow our business? Absolutely. And this business growth will be beneficial to Pennsylvania.

No one company can solve the health care problems of this country alone, but we believe together this consolidation does lead to a pathway for positive change for 10 Pennsylvania and all of our Pennsylvania communities.

Thank you both very much for your time and attention.

[The prepared statement of Mr. Frick appears as a submission for the record.]

Senator SPECTER. Well, thank you, Mr. Frick.

You list a large number of innovations which you propose, and you say that they will be savings to subscribers in the long run. But I am still looking for something specific on savings now in the short run or within a year or two.

You talk about $1 million in economic benefits over a 6-year period. But the question in my mind is: Where is that going to go?

When we talk in the question-and-answer session later, we will get into the $4 billion in reserves which Highmark has and the $2 billion in reserves which Independence Blue Cross has. And the question on my mind is: How much of this $1 billion that you are going to save over 6 years is going to go into reserves and how much is going to go to reduce premiums? I think if you talk about reduced premiums, you have a much more attractive proposition. When you have savings, economies of scale, that is really the money that comes out of the pocket of people, and reduced premiums allow more people to be covered. And you have a great many programs where you decide on the allocations of money, and you give the Commonwealth of Pennsylvania some money. But the Commonwealth of Pennsylvania has many sources of funds.

You talk about people who pay your premiums. This Subcommittee is interested to know what savings there would be for them and what lower premiums would enable more people to have health insurance, would not have to go looking for it someplace else.

Well, those are matters which I would like you to address, Mr. Frick, and we will come back to it in the question-and-answer session. Our next witness is Ms. Carolyn Scanlan, the President and CEO of The Hospital and Healthsystem Association of Pennsylvania since 1995; undergraduate degree from Skidmore College and a master's degree in health services administration from Russell Sage College. Thank you for joining us, Ms. Scanlan, and we look forward to your testimony within 5 minutes.

STATEMENT OF CAROLYN F. SCANLAN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA, HARRISBURG, PENNSYLVANIA

Ms. SCANLAN. Thank you, Senator Specter, and thank you, Chairman Kohl, for allowing us the opportunity to speak today. As you know, Senator, the association represents and advocates for the more than 250 hospitals in Pennsylvania, and we appreciate the opportunity to present our views in regard to the proposed merger.

Over the past year, the association has raised questions and concerns with both Federal and State officials regarding the proposed merger of these two plans and has called for a thorough review by Government. Most recently, in hearings before the Pennsylvania Commissioner of Insurance, we have taken the position of opposition as this merger is currently proposed. We think it is important for the regulators to review the current health insurance marketplace in Pennsylvania, which we believe is already skewed toward Highmark and Independence Blue Cross' advantage, and a merger would create a health plan with an overwhelming presence or "footprint" across the Commonwealth.

We have expressed four areas of concern, two of which are germane to this hearing. The four areas are the issues around competition, provider contracting, social and community mission, and health insurer accountability.

The first two—competition and provider contracting—would fall under the auspices of the Federal agencies, and we were

disappointed that another early termination of review was granted to the plans by the Department of Justice.

With the amount of penetration of already insured people contained within these two plans—and Chairman Kohl and you both referenced those numbers—we have continued concern about the consolidation.

Market competition in health insurance is important, we believe, in achieving competitive premiums—I think as you have pointed out, Senator Specter—for employed groups and, from the perspective of hospitals, competitive payments to health care providers. Both Highmark and Independence Blue Cross already enjoy dominant positions, which make it difficult for that kind of competitive payment.

I am going to leave it to others on this panel to discuss the underlying legal issues of competition, monopoly, and monopsony, which I know that their testimonies will cover. But it is the concern of hospitals and physicians regarding the monopsony power that it has not been properly analyzed and evaluated and serve as a center of HAP's concerns regarding the impact this merger will have. And so at the State level—and we would have, before the Department of Justice, also asked for very specific issues in regard to provider contracting, most-favored-nation issues, all product clauses. We are asking for the ability for providers to jointly negotiate, concerns about the development of an arbitration process, and, last, issues around allowing clinically and financially integrated organizations to negotiate as a unit with the merged plan.

There are three things that we think that this Subcommittee, that you, Senator, could address in the near future.

The first is that we would request a briefing from the Antitrust Division as to why the Division failed to thoroughly investigate the merger. As you know, they do not have to issue any kind of detail on their review, and that would be helpful.

Second, the line of case law that permits the type of market allocation the Blues are involved in is still an unsettled law of antitrust law. And we would ask, in addition to Chairman Kohl's request of the GAO to look at rising health insurance prices, that the GAO also do a study looking at the state of the law in this area and whether Congress needs to ensure that joint ventures that undermine competition, such as the Blues' process of licensure, would be also reviewed from the perspective of competition in the marketplace.

And then, third, as you, along with Chairman Kohl, your colleague on the Subcommittee Senator Grassley, as well as other colleagues in the Senate, Senator Durbin and Senator Whitehouse, said to the FTC, we would ask that both the Department of Justice and the FTC take immediate action to approve the hospitals' request for more guidance on clinical integration by approving in some manner the working paper that was recently developed by a group of antitrust luminaries on behalf of the AHA.

The rest is clearly contained in my testimony, and so I thank you for the opportunity to ask for these three items today.

[The prepared statement of Ms. Scanlan appears as a submission for the record.]

Senator SPECTER. Ms. Scanlan, I note that neither the Hospital of the University of Pennsylvania nor Temple has taken a position here, and when the times comes for Q&A, I would like you to comment on the solidity of the Hospital Association and the opposition which you have articulated.

Our next witness is Mr. Samuel Marshall, President and CEO of the Insurance Federation of Pennsylvania. He has served as counsel to the Insurance Commissioner, previously chief counsel to the Medical Catastrophic Loss Trust Fund; bachelor's degree from Haverford and law degree from Villanova.

Thank you for coming in today, Mr. Marshall, and we look forward to your testimony, 5 minutes.

STATEMENT OF SAMUEL MARSHALL, PRESIDENT, INSURANCE FEDERATION OF PENNSYLVANIA, INC., PHILADELPHIA, PENNSYLVANIA

Mr. MARSHALL. Thank you. Sam Marshall with the Insurance Federation of Pennsylvania. We represent the commercial carriers that we have been talking about obliquely. We represent them in all lines of coverage.

I do not think consolidations are inherently good or bad, whether for competition or consumers. I do think that this one, absent the conditions that we and others have recommended, will be bad on both counts.

The underlying question is whether competition, even more so than consolidation, is good or bad. And I do think that this consolidation will impact competition First off, it gets rid of the potential for Highmark and IBC to compete with each other. They may not intend to do that now under current management, but managements change.

Second, it is going to make it more difficult for other insurers to compete. There is a lot of talk about the ability of other carriers to raise capital. Capital only goes into markets that are open and viable. As you have a dominant, an increasingly dominant market in Pennsylvania, that does not attract capital for the smaller players.

But going to the question of is competition good or bad, it is a legitimate question in the world of health reform. I think that competition is a hallmark of any viable insurance marketplace. I think it makes sure that consumers have choices. I also think it makes sure that insurers, no matter how big or small, face both the opportunities and the penalties that come from either answering or failing to answer consumer demands.

I am a Pennsylvania-centric person, so I will talk about it in terms of examples that we have seen in Pennsylvania over the last 20 years.

In our Commonwealth, veritably every line of insurance has faced the same problems that you see in health insurance now, namely, consumers not getting the coverage they want at a price they can afford. The only answer that has worked in all other lines has been to foster competition. The most prominent example, especially for those from Philadelphia, is our auto marketplace. Back in the 1980s, it was a very limited and expensive market. A number of reforms were tried. The only one that worked was a law in 1990

that was spearheaded by the late Governor Robert Casey, hardly an ally of the insurance industry. But he recognized the need to encourage and reward new carriers, new ideas, and more competition.

As a result, over the past 18 years, the rates have been flat, and there has been broad availability of coverage for all drivers. Would that we had the same result in health insurance.

It has worked in other lines, too. The second more prominent example in Pennsylvania would be workers' compensation insurance. Again, it faced many of the same problems you see in health insurance now. They enacted reforms that brought in new carriers, new ideas and more competition. And that has worked well in that market.

What we have not seen in Pennsylvania are reforms that have encouraged competition in health insurance, and I think that is one of the main reasons we have not seen anywhere near the progress that consumers need.

I do recognize that competition alone is not the only answer, but I would say that if you do not have a strongly competitive health insurance market, all the best intentions, whether they come from Highmark and Independence Blue Cross or from smaller carriers, you simply do not have the cattle prod of the consumers choice making sure that they come to fruition.

Again, I do not think that means that consolidations, even those of this magnitude, are inherently flawed or fatal to the prospect of competition; but I do think that consolidations, especially of this magnitude, have to be scrutinized and only approved if they come with the types of conditions that we and others have recommended in the proceedings before the Insurance Department.

One note in closing: There was an op-ed piece in Sunday's New York Times by William Poole of the Cato Institute on Fannie Mae and Freddie Mac, and I do not get down to Washington much, but I know that is a great debate here. What he talked about was the danger that we are all seeing across the country in allowing a crucial market to have only two operators. And he pointed out that "markets work best when numerous firms compete against each other." I think that is worth remembering here: Any market that becomes a private monopoly is in danger of becoming a hostage to that monopoly, no matter how extensive or well intentioned the regulatory oversight. It is not just that competition gets stifled, and with it the pressure to do better. It is that consumers can be harmed by the absence of the checks, balances, and safety valves that come from a competitive market.

Thank you for the chance to be here. I am happy to answer any questions.

[The prepared statement of Mr. Marshall appears as a submission for the record.]

Senator SPECTER. Thank you very much, Mr. Marshall.

Our next witness is Mr. Michael Laign, President and CEO of the Holy Redeemer Health System, located in Huntingdon Valley, Pennsylvania; previously served as Executive Vice President of the Frankford Health Care System; bachelor's degree from the University of Pittsburgh and an MBA in hospital and health care administration from Temple.

Thank you for coming in today, Mr. Laign, and we look forward to your testimony, 5 minutes.

STATEMENT OF MICHAEL B. LAIGN, PRESIDENT AND CHIEF EXECUTIVE OFFICER, HOLY REDEEMER HEALTH SYSTEM, HUNTINGDON VALLEY, PENNSYLVANIA

Mr. LAIGN. Thanks for having me here. Holy Redeemer Health System is a nonprofit organization which provides a wide range of health care and health-related services, including an acute care hospital, home health and hospice services in Pennsylvania and New Jersey, two skilled nursing facilities, assisted living, a retirement community, low-income housing, an active living community, and a transitional housing and resocialization program for homeless women and children in North Philadelphia.

We employ over 4,000 people. Every day, we touch 20,000 individuals. Twenty-five percent of our revenue is derived from IBC and/or IBC family of products. We offer IBC to our employees as one of their health insurance offerings. We also offer a competitor to our employees as well. I appreciate the opportunity to share our views with the Subcommittee on the proposed merger and consolidation of IBC and Highmark.

While I share some of the fears and concerns expressed by some of the other witnesses here today or that will be expressed, on balance I see this merger as an opportunity to address needed change to the health care delivery and financing system in Pennsylvania. I believe a Blues plan whose core business and interests are focused on Pennsylvania is in our collective long-term interest. Holy Redeemer Health System would rather deal with a plan and a plan leadership with a vested interest in making Pennsylvania a better place to live and work.

I know arguments have been made on both sides of the issue about the competition or lack of competition between Highmark and IBC in southeastern Pennsylvania and other parts of the State.

In a sense both arguments are "right," but both miss the underlying long-term challenge we face in making our health care system better for all stakeholders.

From my perspective, our health care system has and will continue to suffer from an abundance of short-term thinking, everyone, including Government, is out to cut the best deal for themselves at the expense of creating an affordable, sustainable system that serves all of our interests.

I think we all recognize both in Pennsylvania and across the Nation that the rate of increase in health insurance costs is not sustainable over the long run. Employers, consumers, State and the Federal Government are all struggling to maintain coverage not to mention the continuing growth of under- and uninsured citizens.

In short, for us in Pennsylvania I think the merger between Highmark and IBC represents an opportunity to begin to rationalize and transform the health care system in the Commonwealth for the future. This is a once-in-a-generation opportunity to help reform and shape the health care system through an insurance enterprise that by all estimates would be responsible for over 50 percent of the health care lives and revenues in our State.

The merger done properly, with the right leadership, appropriate safeguards and appropriate, sustained Government oversight, could help to, as it has been mentioned: reduce administrative costs; improve quality; achieve greater uniformity in our patient safety and process improvement efforts; improve access to coverage; enhance the affordability of coverage; and, very importantly, create a more transparent system.

If coordinated with complementary and consistent Government health programs and policies, it should be possible to help drive many needed reforms of Pennsylvania's health care system. In making this case, I fully understand how difficult it will be to achieve these kinds of objectives. But not seizing this opportunity will result in business as usual.

A couple of examples of how we have seen glimpses of what the future could be.

IBC has engaged the provider community in a series of partnerships. One is with the Health Care Improvement Foundation, an organization that I chair. That organization formed the Partnership for Patient Care to coordinate patient safety and clinical process improvement efforts. Its focus is to accelerate the effective adoption of evidence-based clinical practices by pooling resources, knowledge, and efforts for all health care providers in our region. Every acute care hospital in the Delaware Valley has participated in the partnership, and it has now been expanded to long-term care providers and other stakeholders.

On another level, my system and IBC and Cardone Industries, a major manufacturer of auto parts with over 4,000 employees in the Philadelphia market, have collaborated to create a virtual partnership for the provision of high-quality, cost-effective health care, wellness screenings, and illness prevention and education services for Cardone and their employees—clearly an effort not only to improve care, but to reduce costs so those employees and those jobs would stay in Pennsylvania.

As I indicated previously, any merger of Highmark and IBC must include some important safeguards or conditions built into the approval process. I have outlined a number of those in my testimony that was written, so I am not going to go into those today. But I would be happy to discuss those—I am looking at the time—during the question-and-answer time.

[The prepared statement of Mr. Laign appears as a submission for the record.]

Senator SPECTER. Thank you, Mr. Laign.

We turn now to Mr. David Balto, Senior Fellow, Center for American Progress, focusing on competition and health care; previously served at the Antitrust Division of the Department of Justice and at the Federal Trade Commission; received his undergraduate degree from the University of Minnesota and his law degree from Northeastern University School of Law. The floor is yours, Mr. Balto, for 5 minutes.

STATEMENT OF DAVID BALTO, SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS, WASHINGTON, D.C.

Mr. BALTO. Thank you, Senator Specter. CAP wants to applaud the Chairman and appreciate the Chairman and the Ranking

Member for all of their hard work and the recent hearings on many antitrust issues which deserve a lot of scrutiny.

I am here representing CAP, several consumer groups, and the National Association of Self-Employed. My testimony outlines at the beginning the alarming trend of consolidation that the Chairman spoke of. The groups I represent feel that every day. The National Association of Self-Employed find it increasingly difficult to provide insurance coverage for their members and their employees, as consolidation has led to increasing premiums.

On the consumer side, this increasing consolidation has led to a dramatic increase in the number of uninsured which have increased by 17 million to one out of every seven Americans over the past several years.

The Highmark-IBC merger may seem complex, but is really relatively simple. Let's go back to Justice Potter Stewart and see what he had to say about the antitrust laws. Thirty-five years ago, he instructed us, "The central message of the Sherman Act is that a business entity must find new customers and higher profits through internal expansion—that is, by competing successfully rather than by arranging treaties with its competitors."

These two companies had a treaty. It was a non-compete agreement. And when that agreement expired, they decided to make that treaty not to compete permanent. And that treaty should be stopped because it will prevent competition in southeast Pennsylvania.

What are the simple facts?

First, IBC and Highmark used to compete in southeast Pennsylvania.

Second, in 1996, they entered into an agreement not to compete. It expired in 2006, and a few weeks later, they entered into this agreement. They could compete right now today. The consumers in southeast Pennsylvania could receive the benefits of that competition.

Third, Highmark's CEO has been explicit about the company's desire to be a statewide provider of Blue Cross/Blue Shield services. Their incentive to expand to the rest of the State is clear.

Finally, we know what the impact of that expansion would be. Highmark entered into central Pennsylvania 6 years ago, and within that 6-year period, because they rolled up their sleeves and they competed, they have acquired a 33-percent market share. And because of that, Senator, CBC rolled up its sleeves, and it is competing more aggressively. And because of all of that competition, employers of all sizes, consumers, and providers are doing better.

Now, imagine, Senator Specter, if it is 2001 and instead of Highmark-IBC, it is Highmark-CBC, and they came in before you and they said, "Please let us merge. We have no desire to enter into central Pennsylvania." And if the antitrust authorities had permitted that merger, all of that competition that has occurred over the past 6 years would be lost.

Now, one of the things that the parties say is we have no intent to enter, but decades of Supreme Court and lower court decisions have said that when you look at the evidence of entry in a potential competition case, you do not accept their assertions at face value. You do not rely on subjective evidence. You look at objective evi-

dence, in part because subjective evidence is just basically the party's statement. And the objective evidence here tells a compelling story that Highmark has the incentive and ability to enter, and that entry would improve competition in southeastern Pennsylvania.

In this regard, I have to say as a former official and antitrust enforcer for over 15 years, it is particularly disturbing that the Justice Department cleared this investigation in less than 60 days on over two occasions. If you did an investigation in less than 60 days, you would not have the time to actually test propositions and seek objective evidence.

Now, let me touch on efficiencies. These parties have made a scale argument: We need this merger because we need to compete better against big guys. That reminded me of the same argument that was made in Philadelphia National Bank, when Philadelphia National Bank wanted to acquire another bank in Philadelphia so it could compete better against the banks in New York. And Justice Brennan said, no, that is not kosher. You cannot go and deprive the consumers of Philadelphia of competition just because you want to compete more aggressively elsewhere.

The law makes it clear that efficiencies have to be merger specific, that there is no less anticompetitive way to achieve these efficiencies. These are two successful, extremely profitable, extremely talented companies, and I would venture to say that on their own they would be able to achieve most of the efficiencies they seek through this merger. Thank you for the opportunity to testify, and I look forward to your questions.

[The prepared statement of Mr. Balto appears as a submission for the record.]

Senator SPECTER. Thank you very much, Mr. Balto.

Our next witness is Mr. Henry Allen, Senior Attorney at the American Medical Association, working primarily on antitrust issues. Prior to joining AMA, he practiced in health care law and litigated cases in forums ranging from the Superior Court of Alaska to the U.S. Supreme Court. Graduated magna cum laude from Washington University, bachelor's degree in economics, and a J.D. master's in public administration.

Thank you for coming in today, Mr. Allen, and the floor is yours for 5 minutes.

STATEMENT OF HENRY S. ALLEN, JR., COUNSEL, PRIVATE SECTOR ADVOCACY DEPARTMENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILLINOIS

Mr. ALLEN. Thank you, Senator Specter. The American Medical Association commends this Subcommittee for leadership in recognizing the threats that unchecked health insurer consolidations pose to the delivery of health care in Pennsylvania and across the country. We appreciate the opportunity to present testimony on consolidation in the Pennsylvania health insurance industry.

In Pennsylvania, where health insurer entry from outside the State has been difficult and little incumbent competition exists, the potential competition that Highmark poses to IBC is the only market mechanism that protects patients from higher premiums.

This potential competition also offers the prospect that physicians practicing in IBC's territories will have somewhere else to sell their services. A merger would foreclose this alternative and deprive physicians of the ability to negotiate competitive health insurer contract terms that touch on every aspect of patient care. Accordingly, the AMA opposes the proposed merger of Highmark and IBC.

The market shares of Highmark and IBC are more than sufficient for the merger to be found presumptively illegal. The merger would result in a combined entity with more than 70 percent of the fully and self-insured commercial health insurance market in the Commonwealth. In short, this proposed merger is so anticompetitive that it results in a statewide monopoly. This monopoly characterization is buttressed by the substantial barriers to market entry. Health insurers that have successfully competed in other parts of the Nation have barely any presence in Pennsylvania. Because there has been little to no entry in either of Highmark's or IBC's dominant market areas, this merger would permanently eliminate each firm's biggest potential rival.

Highmark and IBC assert that they do not compete in the same market, that they operate in different regional markets. Even assuming the insurance market in Pennsylvania is regional, the merger will substantially reduce competition. IBC is dominant in its alleged regionalized market. In the absence of a merger, Highmark's entry as a competitor would result in a substantial deconcentration of IBC's regional market.

IBC has the means, other than through merger, to enter IBC's territory. In the past, Highmark would have marketed its Blue Shield Plan in IBC's territory but for Highmark's agreement with IBC to exit that territory for 10 years. That market division agreement expired around the time this consolidation was proposed. Today, Highmark is free, capable, and desirous of offering its services in the southeastern Pennsylvania territory where IBC presently sells.

There is no meaningful difference between this potential competition and actual competition. As Areeda and Hovenkamp observed in the leading treatise on antitrust law, once a firm like Highmark is recognized as a factor "in future predictions about the market, that firm must be counted as a competitor even though that firm has not yet won its first bid or indeed has not made any bid at all."

To reason otherwise understates the competitive significant of mergers that, like here, occur in highly concentrated, noncompetitive markets. Indeed, where the merger results in a market share of monopoly proportions, the merger should constitute a Section 2 offense of maintaining a monopoly because it eliminates either actual or potential competition.

DOJ's clearance of this merger greatly concerns the AMA. The Government has challenged only three of more than 400 mergers involving health insurers and managed care organizations over the past 12 years. As a result, markets for third-party payers, especially commercial insurance plans, have grown increasingly concentrated. Studies show overwhelmingly that in this market environment, physicians across the country have virtually no bargaining power with dominant health insurers.

Competition is essential to the health of the free market. Competition among insurers forces them to hold the line on premiums and provide improved service. Accordingly, the AMA respectfully requests that this Committee urge the Federal antitrust enforcement agencies to more rigorously enforce the antitrust laws with respect to proposed health insurer consolidations.

Thank you, Senator. I would be happy to answer questions.

[The prepared statement of Mr. Allen appears as a submission for the record.]

Senator SPECTER. Thank you very much, Mr. Allen.

We now turn to Dr. Barry Harris, Principal and Board Chairman of Economists, Incorporated, former Deputy Attorney General for Economics in the Department of Justice Antitrust Division; bachelor's degree in mathematics from Lehigh University and Ph.D. in economics from the University of Pennsylvania.

We welcome you here, Dr. Harris, and the floor is yours for 5 minutes.

STATEMENT OF BARRY C. HARRIS, BOARD CHAIRMAN, ECONOMISTS, INC., WASHINGTON, D.C.

Mr. HARRIS. Thank you, Senator. As you said, my name is Barry Harris, and I am an economist. I have been doing work in antitrust and competition issues for more than 30 years. And as you pointed out, I was at the Department of Justice. I was the chief economist there. My official title was Deputy Assistant Attorney General. I hope to be brief today.

My full testimony was presented to the Pennsylvania Insurance Department, and it is part of the public record. The analysis considered relevant markets; it considered competition within these relevant markets; it considered potential competition; and it considered other issues as well.

The overall conclusion I reached is that there is no basis to conclude that the proposed consolidation of Highmark and IBC would reduce competition. The reason for this is simple. Highmark and IBC do not compete with each other in the sale of commercial insurance for any customer. That is—and this is important—no customer will have fewer choices after the transaction than they do today.

Now, as you have heard, there is a lot of speculation about issues of potential competition, and at least what I have seen is it is just speculation. I agree with Mr. Allen and Mr. Balto that it should be based on objective criteria. And perhaps you may want to ask Dr. Melani later, but he laid out at the PID hearings a list of reasons why Highmark does not believe it is in its interest to enter southeast Pennsylvania in the absence of this transaction.

Now I would like to turn to my overall conclusion, which is that the transaction will not harm competition. Again, as other people have said, the Department of Justice has reviewed this transaction twice. My understanding of that process is a bit different than has been presented.

Thousands of documents were presented to the Department of Justice. The parties gave the Department of Justice additional time so that it could complete its investigation. The Department looked at direct competition; it looked at potential competition; it consid-

ered sales of both commercial and non-commercial products. And twice the Department of Justice provided clearance.

My take on that is that the Department of Justice reached the same conclusions that I have reached, and that is that the proposed consolidation of Highmark and IBC will not lessen competition in any insurance market in Pennsylvania.

One last point. There have been several claims that there is a State market here and that the shares are very high. And it is a basic tenet of antitrust law and competitive analysis that shares only make sense in a properly defined market. And there is no State market for health insurance products in Pennsylvania. If you are a consumer in Philadelphia, you have no ability to access the same products that are offered consumers in Pittsburgh. The prices may differ; the products themselves may differ.

Basically, the product in Philadelphia is not a substitute for Pittsburgh and vice versa. And it is true throughout the State. So, consequently, any shares or conclusions drawn on the whole State do not provide you with the basis for appropriate economic and competition analysis.

Thank you, and I, too, would welcome questions during the question-and-answer period.

[The prepared statement of Mr. Harris appears as a submission for the record.]

Senator SPECTER. Thank you, Mr. Harris.

Our final witness is Dr. Henry Miller, Managing Director of Navigant Consulting, Inc. More than 35 years' experience in the field of health care practice, a CPA, Dr. Miller developed research costing as a method for measuring costs of health services; a bachelor's degree and an MBA from the City College of New York, Ph.D. from the University of Illinois.

Thank you for joining us, Dr. Miller, and we look forward to your testimony for 5 minutes.

STATEMENT OF HENRY MILLER, MANAGING DIRECTOR, NAVIGANT CONSULTING, INC., WASHINGTON, D.C.

Mr. MILLER. Thank you, Senator Specter. As you indicated, I have worked on health insurance and health finance issues for more than 30 years, including work for clients based in Pennsylvania, in other States, and for the Federal Government.

I was asked by UPMC Health Plan to analyze the impact of the proposed consolidation of Highmark and Independence Blue Cross and to testify today on my findings. UPMC is an integrated delivery and financing system and the second largest nongovernmental employer in Pennsylvania. UPMC Health Plan provides commercial group coverage to over 6,000 employers with approximately 330,000 members, Medicare and Medicaid coverage to another 185,000 beneficiaries, and services an additional 700,000 members through a variety of other benefit programs such as behavioral health, CHIP, short-term disability, employee assistance, and wellness programs.

I have prepared a detailed report for UPMC Health Plan on the impact of the proposed Highmark and IBC consolidation, and I would be happy to provide a copy of this report to the Committee

if it is requested. Today, in my testimony I want to concentrate on four issues:

First, briefly identify the markets that are going to affected by the consolidation;

Second, cite evidence that previous health insurer consolidations have not led to administrative savings;

Third, that Pennsylvania's hospitals will be adversely affected by the increased financial pressure that will result from the combined entity's leverage during hospital contract negotiations;

And, finally, that the proposed consolidation will adversely change the market for health insurance in Pennsylvania to the detriment of health care consumers and providers.

There was just some recent discussion on the issue of whether the market was a statewide market or a regional market. My point would be that the commercial health insurance market is a complex market that includes markets that are separate for individuals who are purchasing coverage for small groups and for large groups. And at least some of those customers operate in a statewide market.

Understanding that the health insurance market operates on a statewide basis for some customers is important because the consolidation of Highmark and Independence Blue Cross will create a single entity that will obviously have a dominant market share in the State. In testimony that I provided to the Pennsylvania Insurance Department, I carefully calculated market share for Highmark and IBC in Pennsylvania and determined, based upon the 12 million people who live in Pennsylvania and the 7,649,000 who have commercial health insurance, that approximately these two—not approximately, but these two entities combined will cover 68.8 percent of the population.

When considering a merger or a consolidation, it is important to determine who will benefit. Reduced administrative costs are commonly cited as a benefit of consolidation. Despite the fact that this benefit is cited frequently, it is important to understand that few, if any, health insurance company mergers in the past 10 years have resulted in lower administrative costs. The complexity of health insurer operations and their reliance on information technology has meant that administrative savings have been elusive.

Last year, I served as the financial consultant to the New Jersey Commission on Rationalizing Health Care Resources. The commission was established by Governor Corzine to address concerns about the financial instability of many of the State's hospitals. My review of hospital finances in Pennsylvania raises similar questions about hospitals' ability to withstand increased financial pressure. Pennsylvania hospitals have lower margins, less liquidity, and are less able to cover their existing debt than the average U.S. hospital. More importantly, Pennsylvania hospitals have physical plants that are more than 14 percent older than the plant of the average U.S. hospital. The consolidated Highmark/IBC entity will have extraordinary leverage in hospital contracting at a time when hospitals are considerably less able to withstand that leverage. Analyses that I have completed indicate that reimbursement rates are lower and premiums are higher in States that have health plans with large market shares.

Because of their size, Highmark and IBC already have significant competitive advantages in the Pennsylvania market. Their advantages are evidenced by the difficulty other health insurers have in competing in Pennsylvania as compared to other States. If the consolidation is approved, the combined entity will provide coverage to at least two-thirds of Pennsylvania's residents and have substantial financial resources that can be used to further increase their market share. Consolidation will certainly not make it easier for other health insurers to compete in Pennsylvania and likely will make such competition more difficult than it is today. Furthermore, no meaningful benefits will accrue to the residents of Pennsylvania that offset the impact of the resulting decline in competition.

Thank you.

[The prepared statement of Mr. Miller appears as a submission for the record.]

Senator SPECTER. Thank you very much, Mr. Miller.

Beginning with you, Mr. Laign, you testified that this merger would enhance affordability. Would you amplify that? Do you believe that this merger will make health insurance more affordable?

Mr. LAIGN. I believe that this will give us an opportunity to experiment and try sort of innovative solutions, just as I mentioned with the Cardone organization.

Senator SPECTER. Experiment?

Mr. LAIGN. Or pilots, however you want to look at it, that we will be able to, in fact, work collaboratively not only within the Philadelphia market but across the State.

Senator SPECTER. Well, when you talk about experimentation, it is speculative as to what the result will be. If you—

Mr. LAIGN. Well, I can tell you in a very—

Senator SPECTER. If you have a merger, you have got scrambled eggs. If it does not work out, then what? But your statement was that you concluded it would enhance affordability.

Mr. LAIGN. I did in my testimony talk about a catastrophic plan that I suggested that both health insurers may want to look at that I think would be one potential way that we could make health care affordable. What I was just alluding to, though, was the relationship that we have developed with Cardone, and I can tell you that is a partnership between IBC and industry and a health care provider all geared to providing excellent health care; also, by the way, reducing cost, and a big part of that is through the reduction in utilization of services and the more efficient utilization of services.

For example, we are now looking at ways together to make sure that their employees and their dependents receive all the pharmaceuticals that are prescribed for them. People do not always take their prescriptions according to the way the doctor has ordered. By working together, we think we can create, again, innovative models to address those types of issues. Improving care, reducing cost.

Senator SPECTER. Ms. Scanlan, you cite in your testimony that in central Pennsylvania where Highmark competes with Capital Blue Cross, reimbursement rates for doctors and hospitals are higher. Could you amplify that? Does that competition result in more compensation for doctors and hospitals, as your statement specifies?

Ms. SCANLAN. What I can adequately say—and we have some charts attached to the testimony that we submitted—is that the operating margins of the hospitals in the middle of the State are higher than the operating margins in the rest of the State. Because of the way these agreements are entered into between the plans and the individual hospitals, I am not privy to the absolute numbers of what those payments are. But when we look at the financial stability or status of the hospitals in the central part of the State—

Senator SPECTER. You say their operating margins are higher, but that is not really responsive on the issue as you state in your written testimony, that reimbursement rates for hospitals are higher. Is that so?

Ms. SCANLAN. I cannot, as I said before, speak to the absolute amount of what those reimbursement rates are. The assumption is that it is causative, that the rates are higher, which leads to higher operating margins.

Senator SPECTER. I noted earlier that Temple University Health System and the University of Pennsylvania Health System have not taken stands on this proposed merger. Can you tell us why?

Ms. SCANLAN. I do not know why the individual systems have not taken—or have spoken in a more neutral fashion. Both of those entities are represented on the Hospital Association Board. The process that we went through in the association was to hold regional hearings amongst our members, have a special task force, and then the board evaluated and deliberated about this at numerous meetings. Both the CEO of Temple and the COO of the University of Pennsylvania Health System sit on both the HAP Board and the HAP Executive Committee, and I can tell you that it was a unanimous decision on the part of the board to oppose the merger as proposed.

Senator SPECTER. Did Temple or Penn oppose the merger in your deliberations on the board?

Ms. SCANLAN. No.

Senator SPECTER. They took no position?

Ms. SCANLAN. They, along with the rest of the board, unanimously took the position to oppose the merger as proposed.

Senator SPECTER. So they did oppose the merger.

Ms. SCANLAN. Within the association.

Senator SPECTER. Mr. Harris, are you representing UPMC here today?

Dr. Harris.

Mr. HARRIS. No. I have testified on behalf—

Senator SPECTER. Dr. Miller, you are representing UPMC?

Mr. MILLER. Yes.

Senator SPECTER. Dr. Harris, you have testified that you believe the merger would be beneficial to the health care systems and ultimately helpful to the consumer?

Mr. HARRIS. I believe it will be, but let me just parse out two different parts. I did not work on the calculation of cost savings and efficiencies. I only look at the competitive aspects, and my conclusion with regard to the competitive aspects is there will be no harm to competition, no reduction to competition. And the process of competition causes cost savings ultimately to be passed on to con-

sumers. So, in that regard, yes, I do believe it will be beneficial to consumers.

Senator SPECTER. And that is the basis for your favoring the merger?

Mr. HARRIS. Well, again, I do not want to parse words, but I had a narrow assignment, and that was to look at the process of competition. And I strongly believe that it will have no impact on competition. If—

Senator SPECTER. Well, are you saying that you are not taking a position on the desirability of the merger?

Mr. HARRIS. I mean, I have no specific position. I have only done a competitive analysis. But the process of competition does cause cost savings to be passed on to consumers. So, to the extent these cost savings will be realized, it will be a merger that is beneficial to consumers.

Senator SPECTER. Well, you are talking about cost savings as a result of efficiencies, economy, and size?

Mr. HARRIS. Correct, as an example.

Senator SPECTER. I am just trying to figure out whether you are for it or against it, Dr. Harris.

Mr. HARRIS. I mean, I am not sure how to be clearer. I had—

Senator SPECTER. Well, yes or on.

Mr. HARRIS. My experience is that these kinds of mergers are good for consumers, but I did not do the analysis with regard to the cost savings.

Senator SPECTER. Your experience is they are good for consumers, so you are for the merger.

Mr. HARRIS. Well, in that regard, yes.

Senator SPECTER. Well, is there some other regard?

[Laughter.]

Senator SPECTER. I am just trying to find out your position. I am trying very hard not to lead you. I know how to lead a witness, but I am trying very hard not to lead you.

[Laughter.]

Mr. HARRIS. My analysis of the merger focused on the competitive process, and I see no reason to believe that this competition will cause a competitive harm.

Accepting the calculations of cost savings, that is an important part of the competitive process, so—

Senator SPECTER. No reason to believe that it would not, with the possibility of an exception.

Mr. HARRIS. If you accept it, then I do believe it will be a beneficial merger.

Senator SPECTER. OK. Dr. Miller, there had always been a sense that UPMC, whom you represent, and Highmark had a very close working relationship in the Pittsburgh area. Why is UPMC opposed to this merger?

Mr. MILLER. In my experience, in my experience as a consultant to UPMC, I have not seen the evidence of that close working relationship. What I have seen is that UPMC as a health plan, not UPMC as a hospital provider but UPMC as a health plan, vigorously competes with Highmark and is concerned about the potential impact of Highmark growing larger and with greater surpluses

and having a greater sense of competitive leverage as a result of this merger.

Senator SPECTER. Well, UPMC has some lines of insurance coverage of its own, right?

Mr. MILLER. Yes.

Senator SPECTER. Describe to what extent UPMC has those lines which would put them in a possible competitive situation with Highmark on providing insurance.

Mr. MILLER. Very definitely competitive. UPMC offers coverage in a number of different categories, including what we would normally describe as health coverage, managed care coverage, to about 330,000 people, all of whom are in western Pennsylvania, which means that they are competing directly with Highmark for business. UPMC has 6,000 employers who have currently purchased coverage from UPMC Health Plan. In addition to that, UPMC Health Plan provides behavioral health coverage and other types of coverage as well. But the experience of UPMC Health Plan, the health plan itself, which is a part of UPMC, the experience of the health plan is that it vigorously competes for business in western Pennsylvania with Highmark right now.

Senator SPECTER. Mr. Allen, you have contended that Highmark could easily re-enter the Philadelphia area market because it already has a network of providers there. If Highmark does not compete in southeastern Pennsylvania, what does it mean that they have a network of providers there? Is that activated, operative?

Mr. ALLEN. In prior years, they were the Blue Shield Plan, and it continued to be operating as Blue Shield. And they, therefore—they do have connections with physician groups there. My understanding is that they have the network—I do not know whether those physicians are actually actively contracted. But the Blue Shield Plan is statewide plan, and they are Blue Shield. They have, through Blue Shield, physicians everywhere in Pennsylvania. They are under contract.

Senator SPECTER. So Highmark is operating under Blue Shield in eastern Pennsylvania, southeastern Pennsylvania?

Mr. ALLEN. They had an agreement not to do that. That covenant not to compete with IBC has expired, and with the expiration of that covenant not to compete, they are ready and able, by virtue of their physician relationships, to compete there in southeastern Pennsylvania. That is my understanding.

Senator SPECTER. Mr. Marshall, in your testimony, you contend that the proposed merger between Highmark and IBC would reduce potential competition. Potential competition is obviously a factor. What indicators are that, absent this merger, Highmark would compete with IBC in eastern or southeastern Pennsylvania?

Mr. MARSHALL. First, Senator, I would like to think that at some point the regulatory oversight of the insurance industry would ask that question and perhaps force some competition in that end. I think if State Farm and Allstate were to say let's divide up the State and not compete with one another, there would probably be some pretty extensive regulatory review, and that should happen there.

I think, second, the practice of Highmark itself, it has gone into central Pennsylvania. There is no reason it cannot go east, further

east. I do appreciate that—and I guess, third, they both have—Highmark and IBC must have been somewhat tempted to compete or else they would not have felt a need to have a 10-year covenant against it.

And I guess, fourth, I would like to think that businesses generally want to expand and grow, and businesses generally want to enter into new markets and new territories. Certainly that is the hallmark of all of the companies we represent. And so while current management at Highmark may not have any intention of going east, I would think that there would be future management that very well might.

Senator SPECTER. Mr. Frick, do you have any intentions of going west?

Mr. FRICK. No, Senator. The infrastructure that would be required to build a statewide brand would prohibitive, and it would divert resources and needed funds from serving our customers in southeastern Pennsylvania in the way that they require it. No, sir.

Senator SPECTER. Dr. Melani, do you have any intention of going east?

Dr. MELANI. No, Senator, we do not.

Senator SPECTER. Dr. Melani, how has it worked out in central Pennsylvania where Highmark competes with Capital?

Dr. MELANI. Senator, that is a great question. It has not worked out well. We entered that marketplace in 2002, and the reason we entered that marketplace was at that time we had a substantial amount of business in that marketplace that we shared with Capital Blue Cross. In addition, we had a large number of employees housed in that marketplace. There were 4,000 employees. And we had relationships in that marketplace that had been developed and sustained over 60 years.

At that time, Capital Blue Cross was threatening to talk all the business that we shared into a downstream company owned solely by them, and we were faced with the situation where we were going to lose significant amounts of revenue profitability if that would happen by being forced out the marketplace. So we elected to compete. We went in that marketplace using our brand, Pennsylvania Blue Shield, and established a hospital network to match up with our physician network. Our experience over the last 5 years, although each of the plans—Capital Blue Cross and Pennsylvania Blue Shield—basically took what market we had and split it 50/50, the financial experience has been dismal. Over the 5 years on that book of business, we have a minus 1-percent operating margin on that book of business.

In addition, I think Ms. Scanlan outlined exactly what the problem is. As we have entered that market, the hospitals and physicians have used their market power and the divisiveness that is created by way of having more health plans to raise costs. They have raised the cost of accessing physician services and hospital services, and margins of the hospitals in that region have gone up substantially.

Senator SPECTER. Well, is Highmark competing now with Capital in that market?

Dr. MELANI. We are, and our premiums in that market have risen faster in that market than the other markets we operate in. So it has been a disaster for customers and for us as a corporation.

Senator SPECTER. Dr. Melani, why do you think the Hospital Association is opposed to the merger?

Dr. MELANI. Because they represent hospitals that would like to get paid more money.

Senator SPECTER. And will they be paid less money if the merger occurs?

Dr. MELANI. No, because we will not gain any more market share in the markets we operate in. We will have no more market power in any single market today, so there is no more leverage today than there will be after the merger, so we would be able to—

Senator SPECTER. But you say they are opposed to the merger because they would like to be paid more money.

Dr. MELANI. Yes, they would like to decrease our market position in the marketplace.

Senator SPECTER. Well, you said because they would—

Dr. MELANI. I am sorry. They would oppose the merger -I am not sure why they would oppose the merger, frankly, because it does not change the market dynamics that exist today. We do not compete. We are in different markets, and it does not change the market dynamic between Highmark or IBC and its providers—hospitals and physicians. It just gives us some additional scale to lower our operating costs, get administrative efficiencies, and leverage other kinds of services in the health care cost equation, like pharmaceuticals, durable medical equipment, laboratory services. It would have no impact on physicians and hospitals.

Senator SPECTER. Mr. Marshall, it is my understanding that—or let me just ask you the question. Have premiums gone down due to competition in central Pennsylvania?

Mr. MARSHALL. Have premiums gone down over the last 6 years? No, Senator. Have they gone up by less of a margin than they have gone up in the more concentrated markets? I believe there they have. I also think the one thing that gets left out of all of this, frankly, when an insurer faces competition and, therefore, does not make as much money as it used to, I think that is a good thing for consumers. I think that is a good thing for the marketplace.

Senator SPECTER. Would you repeat what is a good thing for consumers? That is what I have been looking for in this entire hearing.

Mr. MARSHALL. I think if an insurer says that because it faced competition it is not making as much money as it wishes it were, I think that is a good thing for consumers. That is what competition is meant to do for consumers. It I meant to hold down just how much money—

Senator SPECTER. You say premiums have not gone down in central Pennsylvania, but they have not gone up as much as they did in areas where there was not the competition like between Capital and Highmark?

Mr. MARSHALL. That is my understanding. That is my understanding about a year ago, and I cannot speak for what their rates have done in the past year. I also—

Senator SPECTER. Would you find out and let the Subcommittee know?

Mr. MARSHALL. Yes, Senator. I also think the one point that gets left out, it is not just what providers get paid or even what the premiums are. It is also what the quality of the service and the innovations of the service are. You look in the health insurance marketplace in central Pennsylvania and throughout, the innovations that have happened with health savings accounts, transparency, and even a lot of the managed care and utilization controls only came about from competition. That is where the genesis was. It was actually not even among our larger members. It was among some of the very small health insurance members that those ideas came about. You lose that when you do not have a competitive marketplace.

Senator SPECTER. Mr. Frick, I am advised that the Independence Blue Cross reserves are $1.7 billion and the Highmark reserves are $4 billion. Is Independence Blue Cross in a position where you have insufficient reserves?

Mr. FRICK. You are correct, Senator; our surplus is approximately $1.7 billion. That represents only 63 days of claims payments. And in Pennsylvania, the Insurance Department did an exhaustive review in 2005 of the Blues' surplus and came to the conclusion that none of the Blues had excessive surplus. The legislature did a review and came to the same conclusion.

Senator SPECTER. What conclusion was that?

Mr. FRICK. That none of the surplus amounts of the four Blue Plans were excessive.

Senator SPECTER. Who concluded that?

Mr. FRICK. The Pennsylvania Insurance Department, as well as an independent study that was subsequently done by the legislature. And, Senator, we use—the question about using the surplus to benefit subscribers, we do that on an ongoing basis when we do our financial planning, when we set rates, when we plan for investment income. And it enables us to operate at lower margins than our for-profit, publicly traded competitors.

Senator SPECTER. When you say that it is only 63 days of claims payments, but during those 63 days you are also getting more premiums.

Mr. FRICK. Well, our surplus represents—we pay about $850 million a month in claims for services to hospitals and physicians on behalf of our members.

Senator SPECTER. And how much do you get in premiums?

Mr. FRICK. Our premium last year was in excess of $10 billion.

Senator SPECTER. So $850 million in—

Mr. FRICK. $850 million in claims payments per month out of a monthly premium of less than $1.5 billion.

Senator SPECTER. It looks like at $10 billion annual premiums and 850 paid out—

Mr. FRICK. Million a month. To put it another way, Senator, as I said, about 88 cents of our revenue or premium dollars—

Senator SPECTER. Well, the figures you have just given me, you have a deficit. Twelve times $850 million in payments comes to $1.2 billion. So you are losing—are you losing money?

Mr. FRICK. Eighty-eight cents of every—

Senator SPECTER. Do not go back to 88 cents. You told me that you have payments of $850 million a month. Isn't that right?

Mr. FRICK. Did I say 850 or 650?

Senator SPECTER. Well, which is it? I believe you said 850.

Mr. FRICK. Let me check my notes, Senator. I know—

Senator SPECTER. It is only $200 million, Mr. Frick. That is not much among friends.

[Laughter.]

Mr. FRICK. It is significant, Senator.

Senator SPECTER. How much?

Mr. FRICK. It is significant, when you said

Senator SPECTER. Is it 850 or 650?

Mr. FRICK. Let me check my notes.

Senator SPECTER. Take your time. Mr. Frick. Absolutely. It is $850 million a month, yes.

Senator SPECTER. OK. Well, when I multiply 12 times 850, I get $10.2 billion. If your premiums are $10 billion, which you just said, you are losing money.

Did you know he was losing money, Dr. Melani, when you agreed—

[Laughter.]

Dr. MELANI. That is why we need to merge.

Senator SPECTER. That is why he needs to merge, but how about you?

Mr. FRICK. Our operating margin last year was 1 percent. Our investment income was 0.6 percent. We operated.

Senator SPECTER. Now, come on, Mr. Frick, don't start giving me figures—

Mr. FRICK. We are not losing money.

Senator SPECTER. I want to deal with 12 times 850 million, which is $10.2 billion, as composed with—well, take a look at the transcript, Mr. Frick. Your figures, I think, do not add up, and take a look at it and provide the Committee with the information.

Mr. FRICK. Absolutely, Senator.

Senator SPECTER. Dr. Melani, how can a company run as efficiently as Independence Blue Cross with Mr. Frick, although his math may not be too good, how could they get along with only $1.7 billion in surplus whereas you have to have $4 billion in surplus?

Dr. MELANI. Yes, it is a difference in the kind of risk that we each bear. Each of our companies has a different make-up of the book of business that we have in different types of risk that we carry. Certain types of—

Senator SPECTER. Sufficient to have more than twice the amount of reserves?

Dr. MELANI. Yes, Senator.

Senator SPECTER. Why?

Dr. MELANI. Our reserves are also—have also been deemed to be below the excessive level, and although our reserves-

Senator SPECTER. Need to be below the excessive level?

Dr. MELANI. Yes.

Senator SPECTER. What does that mean?

Dr. MELANI. They are at a sufficient level. The Insurance Department has determined that our reserves are in the sufficient level.

Senator SPECTER. Would you repeat that?

Dr. MELANI. They have determined that our reserves are sufficient to cover the risk that we have and not excessive.

Senator SPECTER. Who made that determination?

Dr. MELANI. The Insurance Department, the Pennsylvania Insurance Department.

Senator SPECTER. Would they approve even higher reserves?

Dr. MELANI. Yes, sir.

Senator SPECTER. Is there any limit to what they would approve?

Dr. MELANI. Yes, there is, sir.

Senator SPECTER. What is it?

Dr. MELANI. What they do, Senator, is they look at the risk that you have in your business, because all of us carry different lines of business. Some of us are in Medicare. Some of us are in Medicaid. Some are in commercial business. We have other lines of business, too—workers' compensation, we have vision insurance, dental insurance, all types of businesses that we have. And each of those have different levels of risk.

So the NAIC, the National Association of Insurance Carriers, has established a methodology to do an apples-to-apples comparison, and they take your surplus and they look at the relative risk you have, and they come up with an equation and a number called risk-based capital, and it is a percentage number. And that is how you can compare all of us to see how we are in relative solvency. And then they set up guidelines with that risk-based capital to determine whether or not your organization is solvent or not based on that ratio.

In the State of Pennsylvania, they have capped that ratio at 750 percent. Above that, they consider it excessive, and they begin to do things to bring that level of surplus down.

Senator SPECTER. Let me ask everybody on the panel the same question, starting with you, Dr. Miller. Is there any basis for doctors and hospitals being concerned about this proposed merger on the grounds that there may be too much power in a combined entity which would give them undue power in negotiating payments to doctors and hospitals?

Mr. MILLER. I definitely believe that there is. One of the points that you were just making was that, combined, the surplus—I am familiar with somewhat different numbers, but in the vicinity, a combined surplus of $6 to $7 billion, which is not only high in itself but so much higher than any other insurer would have in the State that it gives them the capability to exert substantial leverage through a number of different approaches. And one of the approaches would be in terms of increased pressure on physicians.

Right now, they exert a considerable amount of pressure on physicians and on hospitals, if for no other reason than because of their size and what that represents of the physician's or hospital's patients. In a typical situation, either IBC or Highmark probably provides coverage to 25, perhaps even 30 percent—about 25 percent of the patients of any one particular hospital, and perhaps even more for some physicians. And when you are in that kind of a position, and now in a position of being even larger and being able to exert greater pressure, then you can obtain substantial discounts. And the evidence is there. One of the points I made in my testimony was that I studied States where Blues Plans had very

substantial market shares of the type that the Highmark/IBC consolidation would create. And in almost every instance, the payment levels, the reimbursement levels to physicians and hospitals are lower than they are in States where there is more competition.

Senator SPECTER. Mr. Frick, do you think that hospitals and doctors have any basis at all for concern about this proposed merger in giving undue leverage and bargaining power to a merged entity? The question Dr. Miller answers in the affirmative, do you think—I know your answer is no, but tell me why.

Mr. FRICK. Well, as you highlighted, Senator—and I was pleased that Temple and University of Pennsylvania and Holy Redeemer and also Children's Hospital of Pennsylvania, Dr. Steve Altschuler, testified in Philadelphia about the importance of our relationship and our partnership. We are all worried about health care costs—

Senator SPECTER. But did Penn and Temple think—did they testify in favor of the merger?

Mr. FRICK. They testified—

Senator SPECTER. They liked your relationship.

Mr. FRICK.—about the relationship.

Senator SPECTER. But did they testify in favor of the merger?

Mr. FRICK. They testified about our partnership and its importance to their institutions and its importance to their patients and our customers.

Senator SPECTER. Mr. Frick, do you think there is any concern that if they testify against you, you could retaliate in some way?

Mr. FRICK. Not at all, Senator. Our products are dependent on access to high-quality hospital and physician networks.

Senator SPECTER. Well, why didn't Temple and Penn testify in favor of the merger then? You are being coached by Dr. Melani—

Mr. FRICK. No, no—

Senator SPECTER.—and that is perfectly—that is perfectly appropriate. You cannot hinder a witness, but you can coach him a little. Go ahead, Dr. Melani. You answer the question. Or is it outside your jurisdiction since—

Dr. MELANI. You would have to ask them because we do not have any idea why they would not testify pro or con.

Senator SPECTER. You do not know why? Do you adopt that answer, Mr. Frick?

Mr. FRICK. I want to explain that in Pennsylvania, I think the hospitals, as well as we are, are concerned about health care costs. But I think the institutions that we deal with in southeastern Pennsylvania are proud of our working relationships. And do I believe they are worried about retaliation or leverage? The market dynamics in southeastern Pennsylvania does not change after the merger, Senator. Our relationships, our products and services, remain the same. We are in two separate markets.

Senator SPECTER. Well, Mr. Frick, it is different as to whether they like the relationship contrasted with whether they favor the merger. That is different.

Mr. FRICK. Yes.

Senator SPECTER. Are you a volunteer, Mr. Balto? Let the record show someone raised his hand.

Mr. BALTO. Yes, I want to reply on a couple things.

First, as a former Government antitrust official for 20 years, I would not rely too much on who complains and who does not complain. I burnt a lot of shoe leather trying to get people to complain about activities by firms that were monopolist, and the problem is, before this merger or after this merger, they are going to have to live with the monopolist so they are going to be reluctant about complaining. Should they—

Senator SPECTER. So you think there is a reluctance about complaining?

Mr. BALTO. Sure. I mean, my experience in mergers, you can ask people at either antitrust agency, they will tell you that that is very common.

Senator SPECTER. Do you think retaliation is not totally out of the picture?

Mr. BALTO. You are going to have to live with these people—whether the merger occurs, you are going to live with a firm with a 70-percent market share one way or another. But what I wanted to do is try to reformulate the question a bit, because what Mr. Harris is suggesting is that all you are doing is changing the name tag on the firm you are dealing with. This is not the operative question here. The operative question here is not whether or not you will have less choices. It is, But for this merger, wouldn't you possibly have more choices? You would have Highmark on the edge of the market, either poised to enter or perhaps entering, and that would improve choices for consumers and for—

Senator SPECTER. Do you think there is a significant likelihood that Highmark would enter Independence Blue Cross' territory?

Mr. BALTO. I think that consistent with the CEO's statements, it is consistent with their past history, and work now the-

Senator SPECTER. Highmark's?

Mr. BALTO. Highmark's past history.

Senator SPECTER. Would anybody—now I have got a lot of hands going up.

[Laughter.]

Senator SPECTER. We are going to have to conclude in a few minutes, but go ahead, Mr. Laign.

Mr. LAIGN. I guess since I am the lone provider, I would like to answer the question, too. I do not feel that this merger will affect their leverage on rates whatsoever. I think the reserves are important. A number of us in the health care industry have been through the failures of insurance companies and the impact that has had on us, negatively. We have ended up getting 50 cents or less on the dollar from those failures.

As a health care provider, I believe cash reserves are extremely important, too. We have 151 days in cash at Holy Redeemer Health System, and I do not believe that is enough, nor do the rating agencies believe that is enough.

I guess what I am hopeful is that the regulators—and I believe they will; I have been extremely impressed with our new insurance commissioner—will do their job and they will provide the necessary oversight of both Highmark and IBC to assure that providers are paid fairly. There are appropriate appeal processes, and we do create—

Senator SPECTER. We have two more hands that are up. I will hear two more responses. Dr. Harris, then Mr. Allen.

Mr. HARRIS. I have known Dave Balto for a long time. We worked together, I guess, in the Government and in private practice. But I have to disagree with him for two different reasons.

One, reading newspaper articles and, in my mind, misinterpreting what is said in those newspaper articles is not how you do an entry analysis. You look at the specific reasons open to that firm. You look at the specific market, and you ask: Will that entry likely be profitable? Moreover—and I just wrote a chapter in an ABA book on this topic. Sitting on the edge of a market does not affect things in that market if entry takes a long time and if a market is difficult to enter. All the testimony here is that this is a difficult market to enter, and he is basically confusing two things. He is confusing what is called a market with no sunk costs, where it is easy to enter, and one where it is more difficult. And in a market like this, having someone at the edge does not have much of an impact on competition. And, moreover, Highmark's analysis says they are not going to enter.

Senator SPECTER. Mr. Allen, you can have—

Mr. ALLEN. Sure. Just to echo a bit on Mr. Balto's point, in southeastern Pennsylvania where IBC now has a 70-percent market share, that is overwhelmingly more than what is required to force physicians to take fees that are anticompetitive, below competitive levels, and compromise their practices. It only takes about a 20-percent market share before physicians basically are over a barrel in their negotiations. So it is a sad day when here Highmark would be, we would say, entering the market, giving physicians an opportunity to—giving physicians an opportunity to have some competition for the contract.

And then, Senator, on the question that you asked me earlier about the ability of Highmark to utilize the physician network in southeast Pennsylvania, their ability to actually come in and give some relief to the marketplace, including the physician market, that information, the information that I have on that came from Monica Noether's report. She has said that, "Highmark already has an existing presence in southeastern Pennsylvania through its professional provider network and its participation in products jointly marketed with IBC in that region. Since Highmark is a professional services plan with providers in southeastern Pennsylvania, Highmark already has an existing physician network under contract in southeastern Pennsylvania." And that comes from a page of Monica Noether's expert report.

Senator SPECTER. Dr. Melani, you have your hand up?

Dr. MELANI. Yes, Senator, thank you. I think a lot of discussion at the table has been about competition, and I think we have clearly stated—and I think it is factual—that we do not compete today and this merger will not change the market dynamics that exist today. Most of the speculations are on potential competition, and it is truly speculation. And a lot of that has been based on statements that are attributed to me, and those statements are correct. I have said that Highmark does have a desire to be a statewide organization. What I also did in those statements was to go on and say I believe there should be one Blue Cross/Blue Shield in the

State of Pennsylvania. And at the time that those statements were made, we were in discussion with IBC about the consolidation, and that was our intended way to become a statewide organization.

We have never, ever stated that we intended to compete in the Philadelphia marketplace, and we do not intend to compete in the Philadelphia marketplace.

Senator SPECTER. Mr. Frick, would you like to have another comment? You and Dr. Melani have the laboring oar here, so I will give you another chance to comment, if you want to.

Mr. FRICK. Well, I view Highmark as a partner. They are not a competitor. We have jointly offered products throughout our history. We have made shared investments for the benefit of our communities. We are both Blue Plans. And we want to continue this relationship in a new and different way, and the $1 billion in net economic benefit to the Commonwealth as a result of this combination is a progressive step forward to address the issues that you have articulated today: affordability, access, and quality. It is what we work to achieve every day, and this combination will certainly improve that for Pennsylvania. And I think our history speaks to that in working together.

Senator SPECTER. Mr. Frick and Dr. Melani, this Subcommittee would be interested in a short statement as to how the merger would impact compensation to physicians, to hospitals—and having extended that request to you, I would extend it to everyone—Ms. Scanlan, Mr. Marshall, Mr. Laign, Mr. Balto, Mr. Allen, Dr. Harris, Dr. Miller—what would the impact be likely on compensation to physicians, number 1; compensation to hospitals, number 2, the impact on premiums which are paid, significantly by employers but sometimes by the individuals; and what impact would it have on the consumers in terms of reducing the number of uninsured consumers and how it would impact on the consumers.

This is going to be an ongoing matter, and I think it would be useful. It has been a very good hearing, and I wanted to be sure it was balanced and asked Highmark and Independence Blue Cross for additional witnesses, and they suggested Dr. Harris and Mr. Laign. We appreciate your coming in. We appreciate all of your coming in. We do not often have nine witnesses at that green-felt table.

That concludes the hearing. Thank you all very much.

[Whereupon, at 4:06 p.m., the Subcommittee was adjourned.]

[Questions and answers and submissions for the record follow.]

QUESTIONS AND ANSWERS

AMA
AMERICAN
MEDICAL
ASSOCIATION

September 8, 2008

The Honorable Herb Kohl
Chairman, Senate Judiciary Subcommittee on Antitrust,
Competition Policy and Consumer Rights
U.S. Senate
330 Hart Senate Office Building
Washington, DC 20510

Re: Senator Specter's Follow-Up Questions for hearing on "Consolidation in The Pennsylvania Health Insurance Industry: The Right Prescription?"

Dear Chairman Kohl:

The American Medical Association (AMA) appreciates the opportunity to respond to your August 15, 2008, letter that requested additional information in response to committee members' questions. We commend all the members of the Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights for their leadership and dedication in examining the impact of health insurer mergers on patients, physicians and employers.

1.) Please provide the Committee with a short statement as to how the proposed merger would likely impact compensation to physicians and hospitals. Also, please provide an analysis of the impact the proposed merger will likely have on the premiums consumers pay and the number of uninsured consumers.

Response: This question, like the core question of Section 7 of the Clayton Act, "requires a prediction of the merger's impact on competition present and future." *Federal Trade Commission v. Proctor & Gamble Co.,* 386 US 568, 577 (1967). In determining the likely

American Medical Association 515 North State Street Chicago Illinois 60610
312 464 5000 www.ama-assn.org

competitive consequences of a merger, market structure counts more than any other single factor. Herbert Hovenkamp, Federal Antitrust Policy, § 12.1a at 444 (1994)

a) Market Structure

In the instant case, Independence Blue Cross ("IBC") has monopoly power. This may be inferred from its approximately 71 percent share of the five county Philadelphia area.[1] *See United States v. Grinnell Corp*, 384 US 563, 571 (1966). IBC derives market power from its high market share, the significant level of concentration within its market, and the high barriers to entry that protect IBC's market share. In Pennsylvania health insurance markets, there has been very little in the way of new entry.[2] Health insurers that have successfully competed in other parts of the nation (including Aetna, United Healthcare and CIGNA) have barely any presence in Pennsylvania. This is consistent with the federal antitrust enforcement

[1] The merging parties contend that insurance markets are "local" and that the affected "physician markets tend to be defined based on Metropolitan Statistical Area ("MSA")." See Response of Highmark, Inc. and Independence Blue Cross to Comments and Questions Raised During the Public Informational Hearing ("Highmark/IBC Brief" pp 8-10). The market share calculation is based on CPS March Supplement data on health insurance and Census population data. Its estimate of the commercially insured population in the Philadelphia five-county area is the denominator for the 71 percent figure. The numerator is IBC's fully insured PA enrollment from its NAIC filing combined with an estimate of their self-insured enrollment (from Note 18 in the Notes to Financial Statements of IBC's NAIC Annual Health Statements). Because IBC's enrollment is primarily in the five county area, this calculation is a reasonable estimate of IBC's share in that area. Based on IBC's estimated share of 71 percent, the minimum HHI for that region would be at least 5,041. A relevant market with a post-merger HHI of greater than 1800 is considered highly concentrated under the United States Department of Justice and Federal Trade Commission Horizontal Merger Guidelines (1992) Sec 1.51(c)

[2] Dr. Monica G. Noether. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filing for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Test From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report, 8-11).

agencies' observation that national plans have been unsuccessful in entering some of the Blue Cross-dominant markets in recent years.[3]

b) The Acquisition Substantially Lessens Competition

For reasons addressed below, Highmark is the most likely entrant into IBC's market. Therefore, Highmark's acquisition of IBC would eliminate the likelihood of *de novo* entry into IBC's market by a firm that could create genuine competition. This is not a speculative concern. Highmark's desire, for example, to acquire IBC demonstrates its desire to enter IBC's market. Highmark, however, does not want to enter the market in a way that would create a competitive market. Instead, it proposes to enter by acquisition so it can preserve the monopoly that currently exists.

The Supreme Court's decision in *FTC v. Proctor & Gamble Co.*, 386 US 568, (1967) ("*Proctor & Gamble*") is instructive. In *Proctor & Gamble*, P&G manufactured a wide variety of household products including cleansers and detergents, but not bleach. Clorox manufactured bleach, and P&G decided to enter that market by acquiring Clorox. The Federal Trade Commission found that Proctor & Gamble was a potential competitor and that the proposed merger would substantially reduce competition in the market for bleach. The Court affirmed this finding based on Proctor & Gamble's prior business decisions and its decision to acquire Clorox. All of the factors the Court relied on in *Proctor & Gamble* are present here.

As in *Proctor & Gamble*, this merger would deny the relevant market its most likely entrant. Highmark has already expanded its services to central Pennsylvania,

[3] "Improving Health Care: A Dose of Competition, Federal Trade Commission and Department of Justice" (July 2004) at 8-11.

where it now competes with Capital Blue Cross. Highmark has the ability and would logically be expected to expand further within its home market of Pennsylvania.

Indeed, Highmark used to operate in IBC's market, and IBC's concern with Highmark's ability to reenter the market is demonstrated by its entering into a ten year non-competition agreement with Highmark. Further, Highmark is already licensed to sell insurance and health plans, has significant experience selling such plans, has relationships with the state's major employers, and has sold its plans throughout the state.[4] Finally, Highmark already has contracts and relationships with a significant number of the physicians in IBC's market, and it could easily use those relationships to enter IBC's market on its own. Highmark/IBC Brief at p. 16 (conceding that Highmark would merely need to "renegotiate its current contracts with physicians"). *See also*, Noether Report, at 15. To enter, Highmark would only have to add a relatively small number of hospitals to its current network. Expanding state-wide is also made easier by the presence of companies that rent networks in Pennsylvania.[5] With the strong appeal of the Blue Shield Trademark, Highmark could accomplish the stated goal of its CEO of gaining state-wide presence.[6]

If there were any doubt about Highmark as the "most likely entrant" to challenge IBC's market dominance, it is dispelled by the ten year covenant not to compete that IBC required of Highmark in 1997 when Highmark sold its interest in two managed care products to IBC. According to Highmark/IBC, the covenant was required so that "Highmark would not launch a new managed care business in the southeast using the Blue brand that would *strip* IBC of the benefit of its purchase."

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[4] Noether Report at 12-16.
[5] For a list of these companies, see Noether Report at 7.
[6] "Talking with Ken Milani," Harrisburg, Patriot News, July 22, 2007.

Highmark/IBC Brief, at 13 (emphasis added). The covenant itself and Highmark/IBC's characterization of Highmark's potential to "strip" IBC of its business attests to Highmark's advantage by both its designation as a Blue Shield franchisee and by its present operations in Pennsylvania.

Overall, the facts of this situation are even stronger than those present in *Proctor & Gamble*. Proctor & Gamble did not manufacture and sell bleach, and its entry into Clorox's market would have entailed its entry into a new line of business. Highmark is already in the business of providing health insurance, just like IBC. This case only involves entry into a new geographic market. Highmark does not want to take its current health insurance products and compete against IBC. Rather, it wants to avoid creating a competitive market, which would benefit consumers by destroying IBC's monopoly.

c) Predicted Injury to Physician Markets

Given IBC's market share of approximately 71 percent, the proposed merger would cement IBC's monopsony power by denying physicians their most likely future alternative to IBC as a buyer of their services. Moreover, but for the merger, Highmark as the perceived potential entrant -- recently freed of its covenant not to compete and poised to enter the market -- would at least continue to exert a competitive influence on the conduct of IBC. See generally Dennis W. Carlton and Jeffrey Perloff, Modern Industrial Organization, 343-47 (3rd Ed. 2000).

One way of estimating the loss of potential competition on physician compensation is to look at what happened in the market immediately after December 6, 1996, when Highmark and IBC entered into their now expired covenant not to compete. IBC unilaterally reduced overall physician compensation as of July 1, 1998

by 20 percent with compensation for some procedures reduced by as much as 45 percent. Premiums were not decreased (see Exhibit 1), illustrating that it is a mistake to assume that, when insurers push down the cost of physician services, their interests are perfectly aligned with those of consumers.[7] Indeed, health insurers that exercise monopsony power by driving physician fees below the competitive level may cause patients to receive an inadequate level of service and quality.[8]

The nature of the health care industry facilitates the potential for a dominant health insurer to exercise monopsony power over physicians selling health care services within a geographic region.[9] Because medical services can be neither stored nor exported, health care professionals have limited options for selling their services to buyers (insurance firms and their customers). If the physicians were to refuse the terms of the dominant buyer, they would likely suffer an unrecoverable loss of revenue. Consequently, a physician's ability to terminate a relationship with an insurer depends on that physician's ability to make up lost business by switching to an alternative insurance coverage plan. Where, as in the instant case, those alternatives are lacking, physicians can be forced to accept inadequate reimbursement rates. Inadequate reimbursement rates will reduce the supply of physician services, despite the demand for such services by patients. Indeed, recent projections by the

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[7] Affidavit of Professor David Dranove at 6-7 (May 13, 2008) submitted in *United States v. UnitedHealth Group Inc. and Sierra Health Service,* Civil No1:08-CV-00322.(see Exhibit 2)

[8] Mark V. Pauly, "Competition in Health Insurance Markets," 51 Law & Contemp. Probs. 237 (1998).

[9] The DOJ has brought merger enforcement actions against health insurers that possessed market shares smaller than IBC's share. The actions were based in part on concerns over the loss of competition in the market for the purchase of physician services. In Aetna/Prudential, the DOJ required a divestiture where the commercial insurance market shares were 63 percent in Houston and 42 percent in Dallas. (*United States v. Aetna Inc.,* Case No. 3:99CV1398-H (N.D. Tex, June 21, 1999) (complaint) paragraph 22 at www.usdoj.gov/atr/cases/f2500/2501.pdf.) In *United/PacifiCare*, it required a divestiture in which the commercial insurance market shares were 33 percent in Tucson and just over 30 percent in Boulder, Colorado. (*United States v UnitedHealth Group Inc.,* Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005) (complaint) paragraph 27 at www.usdoj.gov/atr/cases/f213800/21385.htm).

Health Resources and Services Administration suggest a looming shortage of physicians in the United States.[10] The proposed merger would continue to force physicians in southeast Pennsylvania to accept some of the lowest fees in the nation.

Highmark, IBC, and other health insurers are able to exercise their monopsony power through, among other ways, the exploitation of the DOJ and FTC enforcement policy on physician network joint ventures.[11] This policy may be interpreted to characterize as "anticompetitive" certain physician network contracting arrangements that are ancillary to the implementation of efficiency enhancing health information technology systems or the creation of innovative compensation arrangements that pay physicians, in part, based on their ability to meet or exceed quality or other performance benchmarks. The risk of costly antitrust disputes with insurers and the federal government pursuant to this enforcement policy is discouraging potential advancements in the way physicians care for patients. Accordingly, the AMA is proposing a modification of the existing policy.[12]

d) Predicted Higher Premiums

As a general proposition, monopsonists drive down their buying price by purchasing fewer products. Because there is less product purchased, there is, in turn, less product sold, the economic equivalent to higher prices. That lower physician fees paid by monopsonist insurers may result in higher prices to patients was

[10] See Health Resources and Services Administration, Physician Supply and Demand: Projections to 2020 (Oct 2006) (projecting a shortfall of approximately 55,000 physicians in 2020); see also Merritt, Hawkins, et al., Will the Last Physician in America Please Turn Off The Lights? A Look at America's Looming Doctor Shortage (2004) (predicting a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically beyond the current range of two to five week).
[11] Statement 8, of Department of Justice and Federal Trade Commission Enforcement Policy on Physician Network Joint Ventures. Trade Reg. Rep. (CCH) para. 13,153. (Auguest 18, 1996)
[12] American Medical Association with Sidley Austin LLP, (see Exhibit 3) Physician Networks and Antitrust: A Call for a More Flexible Enforcement Policy, June 2008.

emphasized by R. Hewitt Pate, a former Assistant Attorney General of the Antitrust Division, in a 2003 statement before the Senate Judiciary Committee:

> A casual observer might believe that if a merger lowers the price the merged firm pays for its inputs, consumers will necessarily benefit. The logic seems to be that because the input purchaser is paying less, the input purchaser's customers should expect to pay less also. But that is not necessarily the case. Input prices can fall for two entirely different reasons, one of which arises from a true economic efficiency that will tend to result in lower prices for final consumers. The other, in contrast, represents an efficiency-reducing exercise of market power that will reduce economic welfare, lower prices for suppliers, and may well result in higher prices charged to final consumers.[13]

Moreover, because health insurer monopsonists typically are also monopolists, their lower input prices (for physician services) do not lead to lower consumer output prices (for health care premiums).[14]

One indication of the Highmark/IBC merger's predicted affect on premiums is to again look at the IBC marketplace shortly after the implementation of the covenant not to compete. On or about July 1, 1998, IBC notified some customers, such as the North Penn School Board in Lansdale, of a 32 percent increase in premium. See Exhibit 4. Also a survey conducted by Mercer/Foster Higgins reported that Philadelphia faced the largest premium increase in 1998 among 15 major metropolitan areas analyzed with 7 percent increases compared to 5.7 percent nationally. See Exhibit 5. *See also* studies in response to question 4 infra pp. 12-15.

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[13] R. Hewitt Pate, Asst. Att'y Gen., Antitrust Div., U.S. Dept. of Justice, Statement Before the Senate Committee on the Judiciary Concerning Antitrust Enforcement in the Agricultural Marketplace, at 4 (Oct. 20, 2003), available at http://www.usdoj.gov/atr/public/testimony/201430.pdf.

[14] Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004).

e) Expected Increase in the Number of Uninsured

Research shows that as insurance premiums increase, the ranks of the uninsured grow. A paper by Chernew, M., Cutler, D., and P. Keenan, *"Increasing Health Insurance Costs and the Decline in Insurance Coverage,"* Health Services Research, August 2005, provides the best available evidence linking premium increases to growth in the number of uninsured. That paper finds that a 1 percent increase in premiums results in a net increase in the uninsured of 164,000 individuals. In this region of Pennsylvania, where premiums are "artificially" inflated due to the covenant not to compete, and now the potential merger, it is likely that the ranks of the uninsured will expand more quickly than if the market were competitive.

2.) You mention the benefits of the competition that has occurred in central Pennsylvania between Highmark and Capital Blue Cross, including higher reimbursement rates for providers. Do you know whether insurance premiums have also decreased in that region?

Response: The AMA has not determined whether insurance premiums have decreased in central Pennsylvania as a result of Highmark's competing with Capital Blue Cross. Answering this question would require an empirical analysis that the AMA has not yet undertaken.

3.) In your testimony, you suggest that, now that the non-compete agreement between Highmark and IBC has expired, there is nothing to prevent Highmark from competing with IBC in Southeastern Pennsylvania, including its license from the Blue Cross and Blue Shield Association. It is my understanding, however, that Highmark could have entered that market before the non-compete agreement expired by offering products outside the scope of the non-compete agreement. If Highmark is the most likely entrant

into the Philadelphia area market, why did it not enter during the past decade by offering products outside the scope of the non-compete agreement?

Response: The non-compete agreement foreclosed Highmark from competing with IBC in all managed care products that "use any service mark licensed by the Blue Cross Blue Shield Association" within southeastern Pennsylvania.[15] Without the ability to market its managed care products under the Blue Cross Blue Shield brand, Highmark was not the potential competitor it is today, freed from the covenant not to compete. Pennsylvania consumers have a strong preference for the Blue Shield brand when they select insurance in Southeastern Pennsylvania. *See supra* at pp. 2-3. This preference has not been studied but seems prevalent in states that have had strong unionized labor roots (i.e., Indiana, Michigan).[16] Highmark has repeatedly asserted that its most valuable asset is its Blue brand. *See* e.g. Highmark/IBC Brief at page 14.

During the term of the non-compete covenant and consistent with the loss of its most valuable competitive asset, Highmark and IBC did not compete in commercial markets outside the literal scope of the non-compete agreement. According to Highmark's expert economist, Barry C. Harris, Ph.D., "Highmark does not market commercial health insurance to any employer group or individual in [IBC's market]. Rather, Highmark participates through a Joint Operating Agreement (JOA) with IBC that has been in place for decades, pursuant to which IBC markets joint indemnity (not managed care) products. Under this JOA, Highmark provides, as a component of these indemnity health insurance products

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[15] December 6, 1996 Purchase Agreement between IBC and Pennsylvania Blue Shield, Section 7.2, p.10.
[16] "Jack Steinberg of Philadelphia's teachers union said, "we would have a revolt with our employers if we did not offer a Blues plan." (Christopher Guadagnino, "Market Power of Pa's Blue Plans," *Physician's News Digest*, May 2000, available at http://www.physiciansnews.com/spotlight/500.html, accessed March 14, 2008.)

marketed by IBC, physician services that complement IBC's coverage in southeastern Pennsylvania."[17] Highmark does, however, currently market Medicare insurance products. Plan enrollees and potential customers can search the provider network easily online.[18]

For the reasons expressed below, the covenant not to compete was a *per se* illegal market division agreement.[19] It foreclosed any effective competition for ten years. If, as alleged by Highmark/IBC, any attempted Highmark competition today would only "jeopardize and likely end the Joint Operating Agreement" (Highmark / IBC Brief, at 14), then the same consideration would have been an even more powerful deterrent during the course of the covenant not to compete when Highmark was marginalized by its foreclosure from the Blues' brand. However, even if the two firms never had an intention of competing in the past, this does not necessarily mean that they would not compete in the future. The business world is replete with stories of cartels that broke down due to internal dissension. A merger would eliminate that likely outcome here.

Highmark/IBC claim in a footnote to their brief (at p 16 n24) that the non-compete covenant made at time of sale contains "[P]rovisions that are standard in purchase and sales agreements. It amounted to nothing more in this case."[20] However, the unlawful nature of

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[17] The proposed transaction between Independence Blue Cross and Highmark Inc.; Pennsylvania Insurance Department Public Informational Hearings, July 2008.

[18] http://www.highmarkmedicareservices.com/bene/medpar.html

[19] Professor Areeda explains that "many noncompetition covenants are unilateral market division agreements in the sense that only one party promises to stay out of the other party's market, but not vice versa." In the instant case, IBC paid $350 million to purchase Highmark's managed care assets in Southeast Pennsylvania and promised to stay out of that market for ten years. This fits Professor Areeda's example of a unilateral market division: "[A] firm might pay a rival money to exit from its territory or to stop selling a particular product or service. Or a potential rival might be paid to refrain from entering. In such a case, the payee's gain is of course the payment itself, but the payor's gain would be the higher prices or output that flow from the payee's lack of competition." Areeda & Hovncamp, Antitrust *Law: An Analysis of Antitrust Principles and their Application* 2134d. 2007.

[20] As reported by the *Physicians News Digest*, some observers at the time believed that Blue Shield willingness to exit the market "was a bargaining chip to gain IBC's acceptance of the controversial consolidation of Blue Shield and Blue Cross of Western Pennsylvania to create Highmark Inc." A spokesman for Highmark is quoted in the article as saying he "would argue with the view that the two are linked," although he acknowledged "IBC's approval [of the consolidation] was required." www.physiciansnews.com/cover/497dv.html

the covenant not to compete is made clear from *Palmer v. BRG of Georgia*, 498 U.S. 46 (1990), which held that such agreements are *per se* illegal market division arrangements. There, two providers of bar reviews competed with each other in the area around the University of Georgia Law School. One of them sold the other the exclusive right to market bar review materials in Georgia. The other firm agreed that it would sell such services only outside of Georgia. Though the challenged agreement was contained in the purchase of business assets, the Supreme Court condemned the arrangement as a *per se* illegal market division.

Even assuming for the sake of argument that the legality of the arrangement should be judged as an ancillary restraint under the rule of reason, the effect of the covenant was to maintain IBC's monopoly and was therefore clearly anticompetitive on that basis also. The covenant coincided with drastic premium increases and the physician compensation reduction discussed above.[21] Accordingly, any observed Highmark refusal to compete outside the confines of the covenant should be understood as an unlawful market allocation arrangement.

4.) In your testimony, you assert that health insurance consolidation has not benefited consumers and that "although compensation to physicians has been reduced, health insurance premiums have continued to increase rapidly."

a) Can you cite to any statistics indicating that where more consolidation has taken place, premiums have risen at a faster rate?

Response: Professor James Robinson of the University of California at Berkeley, School of Public Health, has concluded that the market power of health insurers is reflected in premium

[21] *Supra*, pp. 4-7

pricing that outstrips the rate of growth in input costs.[22] This conclusion is consistent with the testimony provided at the Pennsylvania Insurance Department Pittsburgh Public Hearing on July 8, 2008 by Diane Holder, CEO of the University of Pittsburgh Medical Center Health Plan and Insurance Services Division. She stated that insurance premiums are 12 percent lower in those markets in which there is a comparatively lower level of concentration.

Professor David Dranove, who is the Walter McNerney Distinguished Professor of Health Industry Management at the Kellogg School of Management, Director of the Center for Health Industry Market Economics and the Director of *Health at Kellogg,* performed for the AMA a preliminary retrospective review of the Oxford/United Merger in New Jersey. Using data provided by the state of New Jersey on small group premiums, he found evidence that in the two years after the merger, New Jersey health insurers enjoyed 14 percent annual premium increases; United/Oxford's increases exceeded 19 percent. These increases vastly exceeded inflation rates pre-merger as well as national trends over the same period of time.

In the last decade, dozens of major health insurer mergers have resulted in an increasingly consolidated payer market. The AMA's most recent study of the health insurance industry shows that 96 percent (or 299 of 313) of MSAs analyzed by the AMA are controlled by a single insurer with a combined HMO/PPO market share of 30 percent or more.[23] The report further shows that 64 percent (or 200 of 313) of the MSAs were controlled by a single insurer with a combined HMO/PPO market share of 50 percent or greater.[24] In addition, 96 percent of the MSAs studied by the AMA are considered highly

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[22] James C. Robinson, Consolidation and the Transformation of Competition in Health Insurance, Health Affairs, Vol. 23 No. 6 (2004)
[23] American Medical Association, Competition in Health Insurance: A Comprehensive Study of US Markets (2007), available at http:www.ama-assn.org/ama/pub/category/9573.html
[24] *Id.*

concentrated (with a Herfindahl-Hirschman index above 1,800) under the Agencies' Horizontal Merger Guidelines.[25]

Premiums are soaring in this increasingly consolidated environment. As of 2006, premiums for employer-based health insurance rose more than twice as fast as overall inflation and wages for the seventh straight year.[26] Since 2000, the amount that workers pay toward family health-care coverage has skyrocketed 84 percent.[27] Average wages have increased only 20 percent over the same period.[28] Rising health-care costs have forced many companies to scale back or drop coverage.[29] Five million fewer workers were receiving job-based coverage in 2006 than in 2000.[30]

b) If payments to physicians have gone down and premiums have gone up, then profit margins for insurance companies should have risen. Can you cite to any evidence that margins have risen in areas where more consolidation has occurred?

Response: Insurers are reaping monopoly profits.[31] Recent reports on health insurer profits show that the profit margins of the major national firms have experienced double digit growth since 2001. United and WellPoint have had seven years of consecutive double-digit profit growth that has ranged from 20 to 70 percent year after year (through 2003).[32] While

[25] *Id.*
[26] The Kaiser Family Foundation and Health Research and Educational Trust; *Employer Health Benefits 2006 Summary of Findings*
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] *Id.*
[31] James C. Robinson, Consolidation and the Transformation of Competition in Health Insurance, Health Affairs, Vol. 23 No. 6 (2004)
[32] Ha T. Tu, Paul B. Ginsburg, Losing Ground: Physician Income, 1995-2005, Center for Studying Health Systems Change Tracking Report No. 15 (June 2006)

premium levels have risen by double-digit amounts, physician revenues have fallen.[33] The median real income of all U.S. physicians remained flat during the 1990s and has since decreased. The average net income for primary care physicians, after adjusting for inflation, declined 10 percent from 1995 to 2003, and the net income for medical specialists slipped two percent.[34]

Professor David Dranove's preliminary report on the Oxford/United merger in New Jersey, mentioned above, found that United/Oxford experienced post merger a large increase in profitability, with annual profit margins increasing by 7-9 percent. These greatly exceeded pre-merger margins. Although Professor Dranove's data concerning the Oxford/United merger in New Jersey are too limited to draw definitive conclusions about whether the merger was anticompetitive, his findings are consistent with anticompetitive impact and demand further investigation.

This Committee has requested that the GAO perform a study of health insurance industry concentration and the extent to which it has contributed to higher insurance rates and harm to provider markets. This request presents the GAO with a remarkable opportunity, and the AMA would be happy to assist the GAO in its work. It is essential to build a body of evidence describing exactly what happens to providers and enrollees in the wake of health insurer mergers. The pendency of these studies does not mean, however, that Highmark's anticompetitive acquisition of IBC should be tolerated.

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[33] Carol K. Kane, PhD, Horst Loeblich, Physician Income: A Decade of Change, Physician Socioeconomic Statistics (2003 Edition)
[34] Ha T. Tu, Paul B. Ginsburg, Losing Ground: Physician Income, 1995-2005, Center for Studying Health Systems Change Tracking Report No. 15 (June 2006)

The AMA and its membership appreciate the Committee's efforts and guidance in the matter of health insurer consolidation nationally and in Pennsylvania specifically. Please feel free to contact me for any clarifications on the information provided. E-mail and contact numbers are included below.

Sincerely,

Henry S. Allen
312 464 4271
henry.allen@ama-assn.org

Exhibits

Questions for Mr. Balto:

1.) Please provide the Committee with a short statement as to how the proposed merger would likely impact compensation to physicians and hospitals. Also, please provide an analysis of the impact the proposed merger will likely have on the premiums consumers pay and the number of uninsured consumers.

Answer:

As I stated in my testimony this merger poses a significant threat to competition by eliminating Highmark as potential entrant into the Southeastern Pennsylvania market. But for this merger, there is a significant likelihood that Highmark would enter the Southeastern Pennsylvania market and would raise compensation levels to doctors and hospitals and reduce premiums that patients would pay. We know that this is true based on the history of Highmark's entry in Central Pennsylvania, which allowed for a rapid expansion resulting in greater competition, lower premiums, improved service and a better quality level of health care. Economic theory and history teaches us that greater competition leads to lower prices and better services.

2.) What should this Committee do about the problem of health insurer merger enforcement generally and the Highmark/IBC merger specifically?

Answer:

I suggest that this Committee ask the General Accountability Office to conduct a study of the Department's decisions not to take stronger enforcement actions in health insurance mergers. That will better inform this Committee and the affected consumers, doctors and hospitals who depend upon a competitive market why there is not a greater degree of enforcement and the impact of the DOJ's enforcement decisions.

I also suggest that this Committee recommend to the Pennsylvania Department of Insurance that it reject this merger for the reasons stated in my testimony and the testimony of the other witnesses at the hearing who documented that this merger will lead to an elimination of competition and harm to consumers.

3.) You mention that the Justice Department has approved nearly 400 health insurer mergers in the past decade. Can you cite any statistics or provide any information on what the affect of those mergers has been on health insurance premiums?

Answer:

I am not aware of any careful analytical studies that cite the affect of health insurance mergers on premiums. However, from the anecdotal evidence that I have secured I

believe that several health insurance mergers have led to significant premium increases. I think this is an issue that should be studied by the GAO.

4.) In an effort to counterbalance the market power that insurers exercise, the doctors and hospitals have sometimes called for an antitrust exemption that would allow them to jointly negotiate with health insurers. I sympathize with their situation, but I am also concerned that such a measure might, in some cases, keep the premiums charged to consumers higher than what a competitive market might produce. What would be your views on such a proposal?

Answer:

As a former antitrust enforcer I believe that antitrust exemptions should be granted in very limited circumstances. The concerns of health care providers seem very legitimate since the antitrust agencies have become increasingly restrictive in permitting collaboration among physicians. Such collaborations have a significant opportunity for improving competition in the health care market and it is unfortunate that the antitrust agencies have not shown more flexibility in considering these arrangements.

I have attached testimony I provided to the House Judiciary Committee on H.R. 971, which would provide an antitrust exemption for collective negotiations by pharmacies. That testimony outlines the circumstances in which an antitrust exemption might be appropriate.

One additional observation. Permitting health care providers to secure countervailing bargaining power may be procompetitive. The effect of high physician market shares on consumer welfare depends on the pre-existing concentration of health plan purchasing power. *See* Roger Blair & Jill Herndon, *Physician Cooperative Bargaining Ventures: An Economic Analysis,* 71 Antitrust L.J. 989 (2004); Tom Campbell, *Bilateral Monopoly in Mergers,* 74 Antitrust L.J. 521 (2007).

HOWREY LLP

1299 Pennsylvania Avenue, NW
Washington, DC 20004-2402
www.howrey.com

John DeQ. Briggs
Partner
T 202.383.7015
F 202.383.6610
briggsj@howrey.com

September 5, 2008

The Honorable Herb Kohl
Chairman, Senate Judiciary
Subcommittee on Antitrust,
Competition Policy and Consumer Rights
United States Senate
330 Hart Senate Office Building
Washington, DC 20510

Re Highmark Inc. and Independence Blue Cross Consolidation

Dear Senator Kohl:

On behalf of Mr. Joseph Frick and Independence Blue Cross, I am providing the following responses to the questions posed by Senator Specter and forwarded to us through you letter of August 15, 2008.

1. *Monthly revenues from premiums and payouts.* In 2007, monthly gross underwriting income for IBC and its subsidiaries amounted on average to $917 million while monthly claims and other operating expenses amounted on average to $883 Million

2. *How the consolidation will make health insurance more affordable for Pennsylvanians.* The substantial majority of every premium dollar received by the two companies is paid out in provider reimbursements: Highmark and IBC pay approximately 88 cents of every premium dollar to doctors, hospitals and other health care providers. In the circumstances, the parties anticipate that the consolidation will have the effect of moderating future increases in premiums for health insurance products and in some discrete areas there might be the possibility of actually reducing premiums, although given today's inflation rate, a meaningful slowdown in the rate of increase is tantamount to a price decrease. As we have tried to make clear, given the operating efficiencies and savings expected from the consolidation, the companies have committed to holding the administrative fee portion of premiums steady for two years. They also project that greater pharmacy cost savings will be achieved through the consolidation, and these savings also will be reflected in lower costs to customers.

Highmark and IBC each currently make substantial contributions to their respective communities, both through the Community Health Reimbursement ("CHR") Program (pursuant to an agreement with the Pennsylvania Insurance Department) and through further commitments to make health benefits available to those who are frequently underserved. The parties have committed that after the consolidation they will contribute an estimated $350 million to continue

the CHR Program for an additional three years beyond its current 2010 expiration date, and further have committed to provide an estimated $300 million for new initiatives to expand healthcare coverage in Pennsylvania. Accordingly, the parties expect that the consolidation will have a significant impact in reducing the number of underinsured and uninsured residents in Pennsylvania, which is a substantial benefit very much akin to a price decrease for many consumers.

Finally, the new company will not have a position in any market different from the positions Highmark and IBC occupy today. The company will continue to face the same competitors in each market when vying for a potential customer's business. It will be challenged to meet the offerings of those competitors with well-designed and competitively-priced products just as Highmark and IBC are today. The consolidation itself will thus not produce or enable premium increases, and the parties expect that the projected efficiencies will enable the new company to provide greater value to consumers in the form of lower premiums than would otherwise be the case.

3. *The impact of the consolidation on compensation to physicians and hospitals.* Because Highmark and IBC do not compete in the same commercial health insurance markets today, we do not expect that the consolidation could have any material impact on provider reimbursement rates in any of our markets. Generally, Highmark and IBC today do not contract with the same hospitals or hospital groups, and because they do not overlap, the consolidation will not result in the new company having any different position when bargaining with hospitals. For example, if a hospital received 30% of its reimbursements from IBC today, it would receive that same 30%, and not any increased percentage, from the new company after the consolidation. The hospitals in all markets will occupy precisely the same position before and after the consolidation. The parties have overlapping physician contracts in limited instances, but these contracts support different health insurance products, as we have elsewhere explained.

Both Highmark and IBC have worked to meet their respective customers' expectations by offering health benefit programs that include access to the broadest network of providers, including physicians and hospitals. Developing and maintaining these valuable, broad provider networks requires that the companies fairly reimburse their participating providers, and the new company will have every incentive to continue to do so as part of its effort to differentiate itself from other health insurers.

Importantly, no part of the $1 billion in economic benefits expected to be generated by the consolidation is based on any reduction in physician or hospital reimbursement rates. Moreover, and speaking from his personal knowledge of these relevant facts, Michael Laign, President and CEO of Holy Redeemer Health System, testified during the recent Senate hearing, "I do not feel that this merger will affect their leverage on rates whatsoever."

4.a. *IBC concerns about Highmark entry into southeastern Pennsylvania.* As has been explained in other submissions, Highmark left the commercial health insurance business in Southeastern Pennsylvania well over a decade ago. More than 20 years ago, Highmark's predecessor (Pennsylvania Blue Shield) established a managed care business in the Southeastern part of

Pennsylvania. Pennsylvania Blue Shield was not successful in that endeavor and sought to mitigate its losses by combining, in 1991, its HMO business with that of IBC to form Keystone Health Plan East (KHPE) in order to compete more effectively with US Healthcare, which then was the market leader in managed-care in Southeastern Pennsylvania. Six years later, in 1997, Pennsylvania Blue Shield left the managed-care business in Southeastern Pennsylvania altogether, selling its half interest in KHPE to IBC for approximately $350 million.

Given this history of withdrawal, coupled with the reality that:

- Highmark (and its predecessors) and IBC have jointly and continuously offered products in Southeastern Pennsylvania for over 70 years (most recently expanding their cooperation to include Medicare Part D benefits);
- IBC has become a significant distributor of Highmark's vision and dental care products in Southeastern Pennsylvania
- The companies jointly operate the Inter County Health Plan business, and
- IBC and Highmark founded and support the Independence Blue Cross and Highmark Caring Foundation, which helps to provide free or low-cost KHPE coverage to uninsured children and low-cost health insurance to uninsured adults in Southeastern Pennsylvania

it has seemed clear to IBC that Highmark had a lot to lose by entering Southeastern Pennsylvania as a full-fledged competitor of not just IBC but the array of other national providers of health care insurance who service Southeastern Pennsylvania. Furthermore, Southeastern Pennsylvania has over the last decade been a highly competitive market, one that has not seemed to IBC as being especially attractive to Highmark, with Aetna, Coventry and recently United among others all competing for business.

4.b. *IBC's inclusion of a limited covenant by Highmark not to compete on a Blue Branded basis as to managed care business in southeastern Pennsylvania.* When IBC paid approximately $350 million to Pennsylvania Blue Shield for its half interest in KHPE, the parties included in the contract a restrictive covenant under which Pennsylvania Blue Shield (and its successor, Highmark) agreed that it would not turn around and re-enter the Southeastern Pennsylvania market with *a Blue branded* managed-care product. Pennsylvania Blue Shield and Highmark were free to offer a non-branded managed care product, or a branded, non-managed care product. The Agreement containing this reasonable covenant was filed with and approved by both the United States Justice Department and the Pennsylvania Insurance Department.

The covenant was normal for a transaction of that size and nature. It did not reflect any IBC perception that, but for the covenant, Highmark would choose to return to Southeastern Pennsylvania, which it had just abandoned insofar as branded commercial health insurance products were concerned, but it did represent a prudent protection of the value of the assets IBC had just purchased from Highmark.

4.c. *IBC's perception or concern that Highmark might experience the same sort of success in southeastern Pennsylvania that it achieved in central Pennsylvania.* As a member of the Blue Cross Blue Shield Association and as a Blue Plan operating in Pennsylvania, IBC was certainly aware of the competition that developed between Capital Blue Cross and Highmark in Central Pennsylvania. However, IBC was not "concerned" about Highmark entering Southeastern Pennsylvania in the way that it entered Central Pennsylvania for the reasons stated above. Thus, IBC did not expect that Highmark might succeed if it entered the Philadelphia area. The competitive dynamics of the Southeastern Pennsylvania market are very different from those in Central Pennsylvania. For example, any entry into Southeastern Pennsylvania by Highmark would not only require Highmark to abandon IBC as a distributor and joint-venture partner, but it would also require Highmark to enter the New Jersey market on an unbranded basis in much the same way that IBC has done in order adequately to serve the Philadelphia metropolitan area, which spills over into several counties in southern New Jersey (and northern Delaware).

5. *Effect of industry consolidation in general on consumers and testimony of Mr. Allen on this.* There is no reason to expect or assume that consolidation in the healthcare industry, even the substantial consolidation that has occurred across the country, has been or will be harmful to consumers. Health insurance markets are local in nature, and Mr. Allen has presented no analysis showing whether or not the shares he points to were calculated for markets properly defined for competitive analysis. In many health insurer consolidations, the combining parties were not present in the same markets before the transaction, and therefore, the consolidation did not result in any reduction of consumer choice. This certainly has been true of the numerous transactions among Blue plans, most of which had separate territories before consolidation.

Highmark and IBC believe that their consolidation can indeed be beneficial to consumers. The health care industry is undergoing rapid change as participants wrestle with the challenges of access, affordability, and quality of medical care. These challenges are fueling industry trends, including consolidation among physicians, hospitals and insurers that place a premium on scale, investment resources, and efficiency. The trends also include greater consumer responsibility for health care decisions and costs and the increasing importance of leading-edge information technology and infrastructure. Growing consumer responsibility means that insurers will have to provide new products, services and more information to meet the needs of distinct consumer segments, such as direct marketing, risk assessment and wellness tools, standardized health records, and enhancements to information technology. These new products and services require substantial assets and capabilities and are expensive and time-consuming to develop.

HOWREY LLP

We trust that these responses, along with the clearance of the transaction by the Department of Justice after two separate investigations, will provide you with everything that you need at this juncture.

Yours Very truly,

John Briggs

John DeQ. Briggs
Howrey, LLP

Counsel for Independence Blue Cross

ECONOMISTS INCORPORATED
Washington, DC • Emeryville, CA

1200 New Hampshire Avenue, NW
Suite 400
Washington, DC 20036

(202) 223-4700
Fax: (202) 296-7138
www.ei.com

In affiliation with
The Allen Consulting Group, Australia

Barry C. Harris
Direct Dial: (202) 833-5236
harris.b@ei.com

September 5, 2008

Senator Herb Kohl
Chairman, Senate Subcommittee on Antitrust, Competition Policy and Consumer Rights
SH 308
Washington, D.C. 20510

Re: Responses by Barry C. Harris to Questions from Committee Members

Dear Senator Kohl:

My name is Barry Harris. I testified at the Senate Committee on the Judiciary Subcommittee on Antitrust, Competition and Consumer Rights hearing on "Consolidation in the Pennsylvania Health Insurance Industry; The Right Prescription?" on July 31, 2008. In a letter dated August 15, 2008, a copy of which is enclosed, you requested that I respond to the questions asked by committee members that were appended to your letter. My responses to those questions are enclosed. If you have any questions or require additional information, please let me know. As you requested, an electronic version of my responses has been sent to Jeffrey_Miller@judiciary-dem.senate.gov.

Sincerely,

Barry C. Harris
Principal and Board Chairman
Economists Incorporated
1200 New Hampshire Ave., NW
Suite 400
Washington, DC 20036
202-833-5236
Harris.b@ei.com

Responses of Barry C. Harris, Ph.D. to Questions from the United States Senate Judiciary Committee Re: Hearing Entitled "Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription?"

Question No. 1: Please provide the Committee with a short statement as to how the proposed merger would likely impact compensation to physicians and hospitals. Also, please provide an analysis of the impact the proposed merger will likely have on the premiums consumers pay and the number of uninsured consumers.

Response to Question No. 1: The proposed consolidation will likely result in lower premiums paid by consumers. The testimony and reports that I provided to the Pennsylvania Insurance Department ("PID") show in great detail that the proposed consolidation will not cause competition to be reduced in any health insurance market in Pennsylvania. The basis for this conclusion is simple: Highmark and IBC do not compete with each other. They are not rivals, and there does not appear to be a single customer for commercial health insurance who will experience any diminution in choices of health insurance suppliers as result of the proposed transaction. This lack of competition or rivalry between Highmark and IBC does not appear to have been disputed by any witnesses and seems to be conceded even by the opponents of the transaction. Highmark and IBC are not reasonable alternatives for each other because they do not sell commercial health insurance to the same customers in the same geographic markets. This result holds whether the focus of the analysis is on sales to individual purchasers, small-group purchasers or large group purchasers or whether all purchasers are considered jointly. Moreover, Highmark and IBC face competition from several other health insurers in their respective markets.

Because Highmark and IBC do not compete with each other, the proposed consolidation will not cause premiums to customers to rise. There is, however, a strong likelihood that the proposed consolidation will result in premiums being lower than they otherwise would be. The parties and their consultant Booz & Company have estimated that the proposed consolidation will result in approximately $1 billion in synergies. Since the proposed consolidation will not reduce competition, the existence of these significant synergies will tend to lower premiums to consumers from the levels that would exist if

there were no consolidation. In addition, Highmark and IBC have indicated that the consolidated firm intends to use some of the cost savings to offset a portion of the operating expenses that would otherwise be included in health insurance premiums. In particular, the new company has pledged to keep administrative fees flat for two years after it is formed, an action Highmark and IBC estimate will save their subscribers approximately $295 million in premiums.

While I have not formally analyzed the impact of the proposed consolidation on the number of uninsured, there is information in the economics literature that sheds some light on this issue. Cost savings that allow premiums to be lower than they otherwise would be, such as those expected from the Highmark/IBC consolidation, can have a measurable impact on the level of uninsured. For example, a recent study published in *Health Affairs* estimates that a $1000 increase in premiums is associated with a 3.8 percentage-point decline in private health insurance coverage. The associated decline in coverage is higher among young adults (9.8 percentage-point decline) and low-to-middle-income people (6.0 percentage-point decline)[1]. Similar results showing that lower insurance premiums are associated with increased insurance coverage were recently reported in the *Federal Reserve Bank of San Francisco Economic Letter*[2].

In addition to the impact of lower premiums, Highmark and IBC have indicated that the proposed transaction will reduce the number of uninsured in two ways. First, they have indicated that the new company will provide over $300 million to new and existing programs for the uninsured, the underinsured and small business employees. Second, they have also indicated that they will extend their commitment to the Community Health Reinvestment Agreement that was signed with the Commonwealth in 2005.

Finally, I do not expect the proposed consolidation to have a material impact on compensation paid to physicians and hospitals because of the nature of competition in health insurance markets. As I explained in my initial report to the PID, over the last 10

[1] Keenan, Patricia, David Cutler, and Michael Chernew, "The 'Graying' of Group Health Insurance," *Health Affairs*, Volume 25 (2006), Number 6, pp. 1497-1506.

[2] Buchmueller, Tom and Rob Valletta, "Health Insurance Costs and Declining Coverage," *FRBSF Economic Letter*, Number 2006-25, September 29, 2006.

years or more there has been an increasing demand for health insurance products with more inclusive provider networks, a trend that reflects the need of Highmark, IBC and all health insurers to offer strong provider networks. Highmark and IBC have specifically recognized that in order to offer broad competitive provider networks, they need to continue to reimburse providers at competitive levels. To do otherwise would undermine their provider networks and have them risk the loss of subscribers to their competitors. The high level of hospital reimbursement coming from commercial insurers was reported on June 27, 2007 by the Pennsylvania Health Care Cost Containment Council, which indicated that: "Commercial health insurers [in Pennsylvania] continued to provide a disproportionate amount of general acute care (GAC) hospital revenue in fiscal year 2006 (FY06)..."

Question No. 2: You cite a number of other health insurers that Highmark and IBC each compete with in their respective areas. However, these companies appear to have faced significant difficulties competing effectively and building market share.

a. Why do you think that is?

b. Do you think the proposed merger might aggravate that situation?

Response to Question No. 2: In answering this question, it is important to understand that it is based on several inaccurate premises. As I previously explained, both Highmark and IBC compete against a number of different health insurers in their respective markets. In the western region of Pennsylvania, Highmark principally competes with UPMC Health Plan, Aetna, United Healthcare, Health America and CIGNA. In the central region, Highmark principally competes with Capital Blue Cross, Geisinger, United Healthcare, Health America and CIGNA. In the southeastern region, IBC principally competes with United Healthcare, Health America and CIGNA. Highmark and IBC estimate that the shares of competing insurers in these three regions are 44% in the western region, 78% in the central region and 38% in the southeastern region.

First, there is no basis for an assertion that these companies appear to have faced significant difficulties in competing effectively and building market share. These

competing health insurers account for a significant and growing share of total health business, which indicates they offer products at prices that many customers consider desirable. In addition, these competing insurers earn significant profits from their Pennsylvania operations. For example, Aetna reported net income of more than $70 million in 2006 in its Health Annual Statement that was filed with the Pennsylvania Insurance Department. Geisinger reported net income of more than $92 million in 2006. Coventry reported net income of $55.5 million through its HealthAssurance Pennsylvania subsidiary[3]. Similarly, UPMC Health Plan reported net income in 2006 of $17.0 million. These competitors have achieved significant share and significant net income and are clearly companies that compete effectively.

Second, several of these competitors of Highmark and IBC have recently expanded their level of sales. For example, UPMC Health Plan first offered health insurance products in western Pennsylvania in 1998. UPMC Health Plan's CEO (Diane Holder) testified at the PID hearings that UPMC currently has 1.2 million members. A sizable portion of these new members had previously been enrolled with Highmark. UPMC Health Plan's 2006 annual report indicates that its provider network includes more than 80 hospitals (92% of area hospitals) and over 7500 physicians. There has also been notable expansion by other insurers in Pennsylvania. As the data compiled by Booz Allen in its *Opportunity Assessment Report*[4] show, several national, for-profit payors, including United Healthcare Group, Cigna, and Aetna, have increased share within Pennsylvania, particularly in the eastern half of the state. The scale of these national payors has increased the pressure on regional payors such as IBC and Highmark to reduce their own costs per subscriber and per covered life. These cost-savings measures include investing in improved capabilities and increased scale. Conversely, IBC's Blue-branded health membership has declined by almost 500,000 since 2002 while Highmark's membership has also declined significantly.[5]

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[3] Pennsylvania in-area PPO and CCPPO (POS) products are underwritten by HealthAssurance Pennsylvania, Inc. (d.b.a. HealthAmerica). All out-of-area PPO products, HealthAmerica One products, and Ohio in-area PPO products are underwritten by Coventry Health and Life Insurance Company (d.b.a. HealthAmerica).

[4] *See* Feb. 9, 2007 *Project Mercury Opportunity Assessment Report*, IBC-PID-000924-1099, slides 11, 14.

[5] *See, e.g., id.* at 11.

In the circumstances, it would be inaccurate to characterize these competitors of Highmark and IBC as not competing effectively. The competitors of Highmark and IBC have competed both through entry and through expansion. Entry and expansion by existing competitors are comparable in that they both force Highmark and IBC to behave competitively.

Consequently, Question 2a is based on an inaccurate premise. Nonetheless, it is useful to observe that in general suppliers can be successful in a market without having the largest market share. Competitors of Highmark and IBC have been successful because they offer health insurance products at prices that numerous customers desire, which in turn allows these competing health insurers to earn significant profits from their Pennsylvania operations. Whether a consolidated Highmark/IBC or its competitors will have higher shares in the future depends on each company's ability to offer products desired by customers. With respect to Question 2b, the consolidation will not aggravate the situation, because the described situation does not exist. The consolidation, however, will provide Highmark/IBC with approximately $1 billion in synergies that will allow it to improve its products and make them more desirable to customers. The process of competition requires that Highmark/IBC will need to continue offering desirable products to customers in Pennsylvania or lose sales to its competitors.

Question No. 3: You suggest that potential competition analysis only applies if Highmark plans to enter the southeastern Pennsylvania region in the absence of the transaction. However, the courts seem to indicate that potential competition analysis comes into play if the acquiring firm is one of a few likely entrants. Since Highmark has already entered central Pennsylvania and has previously competed in southeastern Pennsylvania, doesn't it seem to be one of a few likely entrants?

Response to Question No. 3: The simple and direct answer is that Highmark does not seem to be one of a few likely entrants into a southeastern Pennsylvania commercial health insurance market. As background, I testified at the PID Informational Hearings that potential competition is an issue that is appropriate to consider in competition analysis only under relatively narrow and particular conditions and, thus, its use in

competition analysis is unusual. I also testified that several conditions must all be present for the concept to apply. The most important of these conditions for the Highmark/IBC analysis is that if Highmark, in fact, would not choose to enter southeast Pennsylvania as a provider of commercial health insurance in the absence of the transaction, then there is no basis to apply the concept of potential competition. I explained these conditions more completely in my 1996 Statement during the review of the BCWP/PBS transaction, and what I said then is still true today:

> For the elimination of potential competition to be of competitive concern, two circumstances must exist. First, it must be shown that competitive problems currently exist in the market. If the market is already functioning competitively due to existing competitors, then the loss of potential competitors would not have an effect on its operation. Second, the potential competitors that are eliminated must be from a very small pool of potential entrants, or at least be the most important and most likely potential entrants.

Taking each of these factors in turn, first, it is important to note that despite the reliance on potential competition theory, there has been no data or analysis presented indicating an existing failure of competition in southeast Pennsylvania or, for that matter, in any other relevant geographic market. Claims that Highmark's or IBC's shares are high do not suggest or establish the existence of a failure of competition. A firm's high share is equally consistent with a competitive market in which, notwithstanding the presence of robust competition, one firm offers the most desirable product and is therefore selected by the majority of consumers. Actual competitive problems would be reflected in unusually high rates or margins, but there is no indication that either Highmark's or IBC's rates (or margins) are unusually high. In fact, high shares can often result from low rates that are highly attractive to individuals and large and small groups.

Second, in the context of the Highmark/IBC consolidation, if Highmark does not plan in fact to enter the southeast region as a provider of commercial health insurance to individuals, small groups, or large groups in the absence of the proposed transaction then, by definition, it cannot be deemed to be the most likely potential entrant. Consequently, there would be no basis to apply the concept or doctrine of potential competition here.

The question for competition analysis is whether or not Highmark would actually enter any of the relevant product markets relating to commercial health insurance in southeast Pennsylvania in the absence of a consolidation with IBC, and, ultimately, the reasons for this decision do not matter. If Highmark will not enter, whatever the reasons for that decision, then it will not become a future competitor of IBC. Nonetheless, it is wholly appropriate to consider the reasons for the decision in order to confirm that Highmark actually will not enter. At the PID Informational Hearings, Dr. Melani (Highmark CEO) provided an extensive list of reasons why Highmark has no intention to enter the southeast Pennsylvania market. These reasons include:

(a) Highmark's adverse experience as an independent competitor in the southeast market. As detailed by Dr. Melani at the hearings and by the company in its submissions to the PID, Highmark's predecessor Pennsylvania Blue Shield lost millions of dollars when trying to compete separately in the southeast regional market. The company reacted first by forming a joint venture with IBC to try to compete more effectively, but ultimately sold its interest to IBC, exiting the market;

(b) Highmark's disappointing experience entering and competing against Capital Blue Cross and others in the central regional market. As detailed by Dr. Melani and the company, after six years in the market, Highmark has a net operating loss. Furthermore, Highmark believes that its activities in the central region have led to Blue-brand confusion among customers. Highmark also has explained that since its entry in 2002, premium increases in the central Pennsylvania regional market have outpaced those in the western Pennsylvania regional market and are now comparable across the markets. The company's actual experience is that Blue-on-Blue competition has not resulted in premium benefits to customers in central Pennsylvania; and

(c) Highmark's entry into the southeast regional market would present more risk than other opportunities the company has for its capital. I understand that Highmark has determined that entry into the southeast market would require substantial costs. These include costs related to the establishment of a competitive provider network, the creation of a marketing presence, the development of a workforce and obtaining necessary

regulatory approvals. The company also believes that successful entry may require the creation of a non-branded subsidiary through which it could operate in contiguous states. Based on its experience in central Pennsylvania, Highmark anticipates that such entry would result in underwriting losses for many years. Highmark has indicated that it has alternative uses for capital that would not include these costs and the risk of harming the Blue brand by creating customer confusion. These other uses include focusing on its outsourcing business and pursuing investments in non-healthcare lines of business (such as stop loss, vision and dental products).

It is my belief that these specific reasons as applied to the southeast Pennsylvania regional market provide a sound basis to conclude that Highmark would not enter the southeast Pennsylvania market.

Highmark has also explained why the southeast Pennsylvania market would present more problems for it than central Pennsylvania and, thus, entry into this market is not a desirable investment opportunity for Highmark. One of these reasons is the large initial investment that Highmark would have to make in order to enter the southeast market. Most of these costs would be sunk (i.e., costs that could not be recovered by Highmark if the entry failed). Section 3.3 of the DOJ/FTC Merger Guidelines explains that high levels of sunk cost increase the scale necessary for successful entry and decreases the likelihood of entry.

Question No. 4: The other factors required for potential competition analysis to apply are high barriers to entry and a concentrated market. Would you argue that these factors are not present in southeastern Pennsylvania? What about western Pennsylvania?

Question No. 5: You cite high barriers to entry as a reason why potential competition analysis should not apply to this merger, but don't high barriers to entry make potential competition analysis particularly apt where there is only one or a few firms uniquely positioned to enter the market?

Response to Questions No. 4 and 5: Again, I believe that these questions are based on inaccurate premises. As I explained in my response to Question No. 3: "For the elimination of potential competition to be of competitive concern, two circumstances must exist. First, it must be shown that competitive problems currently exist in the

market. If the market is already functioning competitively due to existing competitors, then the loss of potential competitors would not have an effect on its operation. Second, the potential competitors that are eliminated must be from a very small pool of potential entrants, or at least be the most important and most likely potential entrants."

One of the inaccurate premises is the failure to distinguish between a market with high concentration and a market with competitive problems. As I explain in detail in my reports to the PID, the economics literature, the federal antitrust agencies and the courts all draw a clear distinction between the two concepts.

As one example, it has been claimed that Highmark and IBC are able to sustain their shares because their prices are lower than the prices of their competitors. Offering product at a lower price than the prices of competitors will generally increase market share, but it is not illustrative of a competitive problem or the exercise of market power. Rather, it is illustrative of a competitive market. I am not aware of evidence indicating that commercial insurance markets in Pennsylvania, including the western and southeastern markets, are not behaving competitively.

A second inaccurate premise is the claim of high barriers to entry. As I explained in my response to Question No. 2, both Highmark and IBC currently face several successful competitors that have been able to expand their sales at the expense of Highmark and IBC. The success of the UPMC Health Plan since its entry into western Pennsylvania 10 years ago, including its ability to capture sales at the expense of Highmark, makes it clear that entry into Pennsylvania markets can be accomplished by offering a product desired by customers. In addition, the ability of other insurers, including Geisinger and the national commercial insurers, to compete against a consolidated Highmark/IBC will help assure that the consolidated firm will not be able to exercise market power or otherwise reduce competition. As I explained in my response to Question No. 2, both Highmark and IBC have lost share in recent years to their existing competitors.

To summarize, first, there is no evidence that health insurance markets are not currently operating competitively. Consequently, there is no basis to apply the concept of potential competition. Second, there has been successful entry and expansion by existing

competitors. Third, Highmark does not intend to enter the southeastern market in the event there is no Highmark/IBC consolidation.

Barry C Harris 9/5/08

Barry C. Harris

The Insurance Federation of Pennsylvania, Inc.

1600 Market Street
Suite 1520
Philadelphia, PA 17101
Tel: (215) 665-0500 Fax: (215) 665-0540
E-mail: mailbox@ifpenn.org

Samuel R. Marshall
President & CEO

August 29, 2008

Honorable Herb Kohl
330 Hart Senate Office Building
Washington, DC 20510

Attention: Subcommittee on Antitrust, Competition Policy and Consumer Rights

Re: Follow-up questions from the July 31 hearing

Dear Senator Kohl:

The following are responses to Senator Specter's questions following the July 31 hearing on the [proposed consolidation of Highmark and IBC.

1. Impact on provider compensation, premiums and the number of uninsureds: We believe the consolidation will lower compensation to providers, without a corresponding incentive for quality and efficiency from providers, because it will lower competition from insurers. Less competition from insurers means a "take it or leave it" power from the controlling insurer in provider compensation.

We also believe the consolidation, with the resulting reduction in competition, will raise premiums for consumers; as with providers, the controlling insurer will have a "take it or leave it" power, with no incentive to hold down rates. Higher rates will increase the number of uninsured.

Highmark and IBC claim the consolidation will produce $1 billion in savings in the first six years. We believe those are more conjecture than firm projections; we also question whether those are savings that are uniquely the result of the consolidation, or could better be achieved by more competition in the market.

2. Rates in Central Pennsylvania: The renewal rates for our largest members in Central Pennsylvania have been roughly between 10%-11% in the past few quarters; in Southeastern Pennsylvania, they have been roughly between 15%-17%. While there are many factors that enter into rate changes, our members say the more competitive environment in Central Pennsylvania is a major reason the rate increases are lower.

3. Conditions to preserve and nurture competition: We refer to the conditions set forth in our July 9 letter to the Insurance Department that was attached to our testimony, in the sections titled "provider contracting", "rating and underwriting restrictions" and "marketing restrictions".

4. "Most favored nation"/"prudent buyer" provisions in provider contracts: These operate as a barrier to entry for other insurers by effectively prohibiting a provider from negotiating or accepting a lower rate from another insurer - because that lower rate for the smaller insurer would then also be extended to the larger one. We do not know whether Highmark or IBC still uses these provisions, and we are not sure what regulatory oversight is in place to examine this. The Insurance Department prohibited Highmark from using these for a period of three years in its November 27, 1996 Order allowing its creation; we know of no other regulatory pronouncement on this.

5. Transparency of provider reimbursements: Lack of transparency harms consumers from knowing what they could or should pay providers in consumer-driven health products,

a key to competition. It also harms consumers seeking to compare how insurers are spending their (the consumers') money when paying providers, which we believe tends to favor the established insurer in a market.

6. Other reforms to promote competition: The conditions we have recommended are comprehensive, so there is not much to add. We would also recommend enactment of Senate Bill 865, the rating reform measures developed by the Rendell administration in its first term; greater enforcement of the Blues' professed social mission to ensure that it benefits society, not the Blues (just as our payment of premium taxes does); and enforcement of existing laws - specifically Section 5 of the Unfair Insurance Practices Act - that we believe prohibit agreements among insurers (including the Blues) to compete with each other.

Thank you for the opportunity to comment on this. Please know that the Insurance Commissioner has published a notice that will appear in tomorrow's Pennsylvania Bulletin closing the public comment period on the proposed consolidation on September 30. We assume this includes any comments from your committee or Senator Specter, and we hope your committee and Senator Specter get any comments you may want the Commissioner to consider by that deadline.

Sincerely,

Samuel R. Marshall

ReedSmith

Debra H. Dermody
Direct Phone: +1 412 288 3302
Email: ddermody@reedsmith.com

Reed Smith LLP
435 Sixth Avenue
Pittsburgh, PA 15219-1886
+1 412 288 3131
Fax +1 412 288 3063
reedsmith.com

September 5, 2008

By Fax: (202) 224-9787

The Honorable Herb Kohl
Chairman, Senate Judiciary
Subcommittee on Antitrust,
Competition Policy and Consumer Rights
United States Senate
330 Hart Senate Office Building
Washington, DC 20510

Re: Highmark Inc. and Independence Blue Cross Consolidation

Dear Senator Kohl:

On behalf of Dr. Ken Melani and Highmark Inc., I am providing the following responses to the questions posed by Senator Specter and forwarded to us through your letter of August 15, 2008, as well as a response to a question posed at the July 31, 2008 hearing.

1. The Likely Impact on Premiums. The parties anticipate that the consolidation will have the effect of moderating future increases in premiums for health insurance products. The substantial majority of every premium dollar received by the two companies is paid out in provider reimbursements. In 2007, Highmark paid 90 cents and IBC paid 88 cents of every premium dollar to doctors, hospitals and other health care providers. In light of the operating efficiencies and savings expected from the consolidation, however, the companies have committed to holding the administrative fee portion of premiums steady for two years. They also project that greater pharmacy cost savings will be achieved through the consolidation, and these savings also will be reflected in lower costs to customers.

Moreover, the new company will not have a position in any market different from the positions Highmark and IBC occupy today. The company will continue to face the same competitors in each market when vying for a potential customer's business. It will be challenged to meet the offerings of those competitors with well-designed and competitively-priced products just as Highmark and IBC are today. In sum, the consolidation itself will not produce or enable premium increases, and the parties expect that the projected efficiencies will enable the new company to moderate future premium increases.

2. The Likely Impact on Physician and Hospital Compensation. Because Highmark and IBC do not compete in the same commercial health insurance markets today, we do not expect that the consolidation could have any material impact on provider reimbursement rates in any of our markets. Highmark and IBC today contract with almost entirely different sets of hospitals and hospital groups, and because they do not meaningfully overlap, the consolidation will not result in the new company having any different position when bargaining with hospitals. For example, if a hospital received 30% of its reimbursements from Highmark today, it would receive that same 30%, and not any increased percentage, from the new company after the consolidation. The hospitals in all markets will occupy precisely the same position before and after the consolidation. The parties have overlapping physician contracts in limited instances, but these contracts support different health insurance products and are not expected to be the source of cost reductions after the consolidation.

Both Highmark and IBC have worked to meet their respective customers' expectations by offering health benefit programs that include access to the broadest network of providers, including physicians and hospitals. Developing and maintaining these valuable, broad provider networks requires that the companies fairly reimburse their participating providers, and the new company will have every incentive to continue to do so as part of its effort to differentiate itself from other health insurers.

Importantly, no part of the $1 billion in benefits expected to be generated by the consolidation is based on any reduction in physician or hospital reimbursement rates. Moreover, and speaking from his personal knowledge of these relevant facts, Michael Laign, President and CEO of Holy Redeemer Health System, testified during the recent Senate hearing, "I do not feel that this merger will affect their leverage on rates whatsoever."

3. The Companies' Response to Dr. Lawton Burns. Our evaluation of Dr. Lawton Burns' testimony revealed that his conclusions regarding limits on economies of scale are based on economic studies that are outdated and no longer useful for evaluating minimum scale in today's healthcare markets or for predicting the efficiency gains likely to be realized from the consolidation. The cited studies focus on an unrepresentative segment of the industry and are based on old data from a health care market that was markedly different from today. The studies focus solely on HMO plans, which now account for only a small segment of the health insurance market. Only 20% of Highmark and IBC's covered lives are in commercial HMO products. Furthermore, two of the studies are based on data from 1988-1991 and another on data from 1985-1997. In the more than twenty years since the oldest of this data, the health insurance industry has substantially changed focus from an earlier emphasis on influencing provider behavior through capitation to a consumer-driven approach in which insurers seek to influence customers' behavior through various financial incentives. In a frank acknowledgment, one of the cited studies specifically stressed that such a change in the health insurance market would render reliance on its findings "problematic for the purposes of policy analysis." Importantly, these studies predate the substantial escalation in costs in the last twenty years associated with developing and maintaining information technology. The companies expect to realize cost reductions of approximately $258 – 328 million over the first six years through efficiencies related to information technology management. I am attaching hereto the parties' submission to the Pennsylvania Insurance Department that addresses these points in further detail.

Two additional points regarding the parties' methodology for evaluating the expected efficiencies are important to understand:

(a) The projected cost savings are expected to be achieved through consolidating functions (economies of scale) and by improving process performance to the best practice across the two companies (cost function shifting). The economic literature that Dr. Burns cites specifically recognizes the ability to achieve economies of scale and to shift cost functions as primary sources of efficiencies resulting from consolidations.

(b) The companies applied a conservative methodology to identify and estimate the expected cost savings. The scale economies were estimated through a detailed study that identified duplicative costs, infrastructure, processes and functions, and the scale-based procurement savings were estimated by comparing purchase prices across the two companies. Similarly, the "best practices" efficiencies were initially estimated by measuring and comparing performance metrics across the companies for the same function and estimating that the combined company could achieve the better level of performance, and where possible, comparing the results to industry benchmarks. In hearings before the Pennsylvania Insurance Department, Booz and Company identified multiple large health insurance transactions that resulted in substantial efficiencies. Testimony of David Knott, July 15, 2008 Hearing Transcript, pp. 118-120.

In sum, Dr. Burns cites only outdated studies of a very different health insurance industry in support of his contention regarding economies of scale. Those studies simply do not have any further force and are irrelevant to the analysis of the proposed consolidation.

4. The Consolidation Will Not Reduce Potential Competition. The consolidation will not have the effect of reducing potential competition in any Pennsylvania health insurance market. As an initial matter, we do not agree that any evidence has demonstrated either that the southeast Pennsylvania market does not perform competitively or that the market is characterized by high barriers to entry. Furthermore, it is simply incorrect as a matter of fact to label Highmark as a "potential entrant" into that market. There is no factual evidence indicating that Highmark would enter the southeast market in the absence of the consolidation. The only evidence is to the contrary.

As I explained during the recent public hearings conducted by the Pennsylvania Insurance Department, Highmark exited the southeast market in 1997 and since that time has never included re-entry in its strategic planning. Highmark withdrew entirely from its southeast managed care business by selling its interests to IBC. In this arms-length transaction, IBC paid $350 million for Highmark's interests and also negotiated a restrictive covenant that Highmark would not launch a new managed care business using the Blue Shield brand in the southeast that would strip IBC of the benefit of its purchase. Highmark then focused on its core geography and products and on potential new products that were more likely to be successful. In fact, it was at this time that Highmark increased its vision and dental businesses, which have been highly successful. Since its exit, Highmark has not performed any study, analysis or evaluation of potential re-entry into the southeast.

Furthermore, Highmark's experience in central Pennsylvania reinforces its decision not to compete independently in the southeast. In 2002, Highmark and Capital Blue Cross were unable to overcome business differences and discontinued their joint operating agreement. At that time, Highmark had a substantial presence in central Pennsylvania. It had become one of the largest employers in the area, and its thousands of employees were deeply engrained in the community. Highmark received hundreds of millions of dollars in managed care revenue as well as substantial revenues from traditional indemnity products. Highmark made the decision to remain in the central region as an independent competitor, and thereby attempt to preserve the very substantial revenues the company derived from its existing business. Although Highmark was familiar with the central Pennsylvania region, its attempt to establish itself as a successful, independent competitor has been disappointing. The company's evidence demonstrates that:

- More than five years after its launch, Highmark continues to operate at a loss in central Pennsylvania;
- Highmark's customers in central Pennsylvania experienced premium increases at a steeper rate than did Highmark's customers in the western region during this same period. Since 2002, Highmark's premiums for PPO fully-insured business in central Pennsylvania have risen faster than they have in western Pennsylvania, and today are comparable in the two markets. Thus, "Blue-on-Blue" competition in central Pennsylvania has not resulted in lower premiums;
- Highmark's costs have increased dramatically during the period, much of which is attributable to the higher reimbursement rates necessary to maintain powerful, well-positioned providers in the network; and
- Highmark believes that its activities in the central region have diluted its most valuable asset – the Blue brands – by creating confusion between Highmark and Capital Blue Cross.

Finally, it is important to understand that re-entry into the southeast region would present substantially more risk than many other uses of Highmark's capital. As I described during the Informational Hearings, Highmark's experiences provide substantial support for the concern that re-entry into the managed care business in the southeast region would expose the company to even worse results than those it has suffered in central Pennsylvania.

In contrast to the central region, Highmark has much to lose by re-entering the southeast. Today, Highmark has a willing partner in the region with whom it has positive, profitable relationships. Highmark has an established marketing arrangement for its dental and vision products through IBC, and entering the southeast on a competitive basis would almost certainly spell the end of this advantageous arrangement. Furthermore, entry would jeopardize and likely end the JOA with IBC for indemnity business.

Furthermore, the characteristics of the southeast market suggest that Highmark's re-entry would present significant risks. The market already contains a number of national incumbent competitors in addition to IBC. Highmark's experience with branded competition in central Pennsylvania demonstrates that it takes many years for the investment to break even when competing against another Blue brand.

Re-entry would require significant start-up costs, including for example, those related to the establishment of a quality provider network, a marketing team and the necessary physical facilities in the region, as well as the costs related to regulatory approvals. It would present daunting actuarial and other business challenges given that Highmark has little information regarding the market's risk characteristics. In addition, successful entry likely would require the establishment of the framework through which Highmark could operate on a non-Blue branded basis in contiguous states, something Highmark does not do. IBC has found it necessary to do so, and it is reasonable to expect that Highmark would conclude likewise. These factors, combined with Highmark's experience in central Pennsylvania provide a basis on which to expect that Highmark would experience financial losses for a number of years, likely even longer than in central Pennsylvania. Highmark's experience in central Pennsylvania also provides substantial reason to expect that Blue-on-Blue competition would not necessarily reduce premiums to consumers in the southeast.

Moreover, more profitable and less risky potential uses of Highmark's capital are readily available. These include, for example, developing Highmark's business as a leading vendor in administrative services for health insurers, including outsourced health care claims processing; and making additional investments in non-healthcare businesses such as stop loss, and vision and dental products and services. The only facts indicate that today Highmark has much to lose and little reason to believe that re-entry into the southeast market would be beneficial for the company or its customers.

Furthermore, the Department of Justice, which twice reviewed the consolidation, specifically investigated the potential competition issue. The parties provided substantial relevant information to the DOJ, which ultimately concluded not to challenge the transaction on this (or any other) basis.

5. Premiums in Central Pennsylvania have Risen Faster than those in Western Pennsylvania. As discussed above, Highmark's rate of premium increase since 2002 in central Pennsylvania has been steeper than the rate of increase in western Pennsylvania. I attach a chart that illustrates both the increase in premiums in central and western Pennsylvania as well as the current situation in which the premium rates are now comparable.

6. The Consolidation Will Not Result in Increased Costs to Consumers. The companies believe that the consolidation is the best tool they have to try to control escalating healthcare costs. The efficiencies and cost savings we have identified in the Opportunity Assessment are only available if the companies combine their complementary operations – neither of the companies will be able to achieve these savings on a stand-alone basis. Accordingly, we believe that if the companies do not consolidate, they are each likely to incur higher costs and be required to seek steeper premium increases than if they are able to consolidate and achieve the expected cost savings.

7. The Likely Impact on the Uninsured [posed during the hearing]. Highmark and IBC each currently make substantial contributions to their respective communities, both through the Community Health Reimbursement ("CHR") Program (pursuant to an agreement with the Pennsylvania Insurance Department) and through further commitments to make health benefits available to those who are frequently underserved. The parties have committed that after the consolidation they will contribute an estimated $350 million to continue the CHR Program for an additional three years beyond its current 2010 expiration date, and further have committed to provide an estimated $300 million for new initiatives to expand healthcare coverage in Pennsylvania. Accordingly, the parties expect that the consolidation will have a significant impact in reducing the number of underinsured and uninsured residents in Pennsylvania.

Sincerely,

REED SMITH LLP

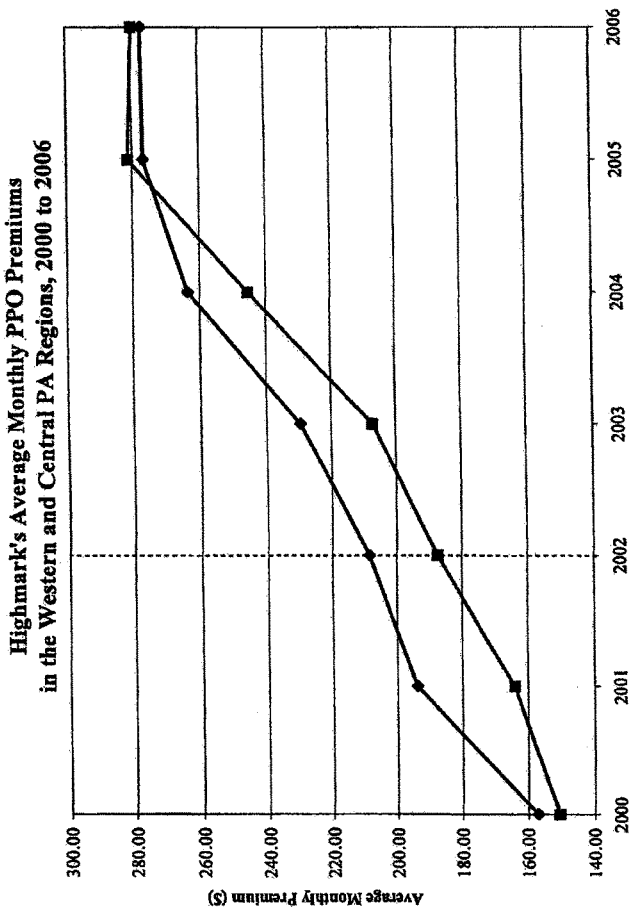
By: Debra H. Dermody
Debra H. Dermody

DHD:da

Attachment

cc *(by email)*: Jeffrey_Miller@judiciary-dem.senate.gov

CONFIDENTIAL



Notes: [1] The 2002 break-line indicates the time of when the Highmark - Capital Blue Cross /OA breakup took place.
[2] The 2000 data includes Non-Risk Premium Revenue and Member Month amounts.
Source: "CPA Premium Revenue Analysis.xls" and "WPA Premium Revenue Analysis.xls", recieved from counsel on February 20, 2007.

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

August 29, 2008

The Honorable Herb Kohl
Chairman, Senate Judiciary Subcommittee on Antitrust,
Competition Policy and Consumer Rights
U.S. Senate
330 Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Kohl:

We are pleased to respond, to the best of our ability based on limited public data made available to HAP, to your August 15, 2008, letter requesting additional information in response to questions from committee members.

1.) Please provide the Committee with a short statement as to how the proposed merger would likely impact compensation to physicians and hospitals. Also, please provide an analysis of the impact the proposed merger will likely have on the premiums consumers pay and the number of uninsured consumers.

Response: Based on publicly available data, experience has shown that in the regions of the state—the south central and Lehigh Valley areas—that have more robust health insurer competition (multiple Blue and commercial health insurer plans) there has been a more stable hospital financial picture over time. (See attached charts that compare hospital financial status by Blue Cross plan service areas.)

The merged plan will account for a majority of the commercial revenues of most hospitals and physicians in the state. Given the resulting market power of the plan, it could drive provider reimbursement levels below competitive levels needed to sustain the provision of quality health care to the citizens of the commonwealth. This purchasing power could pose a risk that could adversely affect health care practitioners, hospitals—which in addition to providing needed care also significantly contribute to the economic vitality of community—and ultimately consumers seeking access to quality health care across the commonwealth.

A dominant plan can also cause payments to providers to be suppressed below an appropriate level, and particularly for hospitals, this suppression can impact payment by Medicare, particularly through Medicare's calculation of what is

4750 Lindle Road
P.O. Box 8600
Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax
www.haponline.org

called an area wage index. Data that was recently released by the U.S. Labor Department showed that among similar sized metropolitan areas, salaries for nurses in the Pittsburgh area were generally much lower. This type of factor impacts calculations for Medicare and creates a difficult cycle for providers seeking to recruit and retained qualified health care professionals.

There is not consistent or complete information available publicly in Pennsylvania across all types of health insurers or across the various product lines (commercial, Medicare, and Medicaid) for analysis that would enable HAP to opine on the potential impact of the merger on the premiums consumers pay or on the impact of the merger on uninsured individuals. HAP has called for continuation of the plans' social and community mission to assure that the plans continue the obligation of being the insurer of last resort and that they continue financial support for Pennsylvania's uninsured programs—CHIP and adultBasic.

2.) *In your testimony, you mention that in central Pennsylvania where Highmark competes with Capital Blue Cross, reimbursement rates for doctors and hospitals are higher, producing a "more stable" financial picture. In a competitive market, one would also expect to see lower premiums for consumers. Are premiums lower in central Pennsylvania? If so, can you provide some statistics supporting that? What is your response to Dr. Melani's contention that premiums have grown faster in central Pennsylvania than other places in Pennsylvania?*

Response: The attached charts suggest that a more robust insurance market has a relationship to the more stable financial picture for hospitals. Unfortunately, there is not a public data source that would allow us to provide trend information regarding insurance premiums for consumers. HAP has called on the Pennsylvania Insurance Department to require consistent reporting of such information so that public policy makers—such as your committee, purchasers, and consumers would be able to better evaluate health insurance trends, including the cost of health insurance.

In 2008, the Pennsylvania Insurance Department began posting rate filings on line, making these requests by health insurers more accessible to the public. Recent filings by Highmark for various health insurance products in its western region and in the central region (that is the area of the state where Highmark competes with Capital Blue Cross) call for rates increases generally of 8.9%. There did not appear to be much difference in the rate increase requests for central and western Pennsylvania. More detailed information to evaluation Dr. Melani's contention would have to be supplied by the plan.

3.) You argue that the merged firm should be prohibited from including "most-favored-nation," prudent buyer, all-product and other similar clauses in its provider contracts.

a. Can you explain a little more how these contract provisions work and how they impact competition among health insurers and the ability of new entrants to enter a market?

b. It is my understanding that the Pennsylvania Insurance Commissioner must approve such contract provisions? Why does that not provide adequate protection against the anticompetitive effect of such provisions? Do you know whether either Highmark or IBC currently use such provisions in their provider contracts?

Response:

a) "Most-favored nation" contract provisions require a provider to contract with a dominant health plan at the most favorable rate it offers and prohibit the provider from contracting at such a rate with any other health insurer. "Prudent buyer" contract provisions seek to achieve the same result.

"All product" contracts can require health care providers to participate in all the product lines offered by a health insurer, including indemnity, PPO, HMO, point-of-service, and governmental products. Typically, "all product" contracts are approached as "take it, or leave it" contracts resulting in providers being pressured to take the terms of a contract even if some of the provisions—such as utilization review, administrative requirements, etc.—for some of the products and/or rates are problematic.

Providers must be allowed to negotiate with health insurers and evaluate the terms of contracts for product lines individually. Given the market power and vast footprint that the merged plan will have, it is unlikely that hospitals or physicians who serve patients could "walk away" from the terms dictated by the plan. Given the magnitude of market power of the merged plan, there need to be appropriate parameters—e.g., checks and balances—so that there isn't unchecked use of market power in these negotiations. Failure to establish effective parameters could result in contracts that unduly drive down provider reimbursement to inadequate levels, thus jeopardizing access to quality health care and the long-term financial sustainability of essential community health care services.

b) In Pennsylvania, health insurers file model contracts with the Insurance Department and then contract individually with hospitals. The individual

hospital contracts typically include a provision that the terms of the contract are proprietary and that disclosure of those terms is a violation. The terms of the individual contract may be altered by either the plan or the provider in negotiation. The individual contracts are subsequently filed with the Insurance Department but are not necessarily substantively reviewed. Therefore, several years ago, even after the Insurance Department had issued notice to health insurers that "most-favored nation" clauses were prohibited, they continued in use in a number of hospital contracts with Highmark for a period of time, because of the proprietary nature of the individual hospital contracts. It is for this very reason that HAP is calling for clear and unambiguous prohibitions against these provisions.

Because of the proprietary clauses in hospital contracts, HAP would not be aware of specific clauses in existing contracts between hospitals and Highmark and/or Independence Blue Cross. I would note that in filing responses to the Pennsylvania Insurance Department's questions, it was reported by Highmark that they do not have most favored nation clauses in their provider contracts. Independence Blue Cross reported that it did have contracts with two providers that contained "a representation by the providers that as of the execution date or effective date of the agreement, their rates are market competitive with their other contracts then in effect." It is unclear from the information by the plan whether this language could be construed as "most-favored nation," albeit in another form.

4.) *In your testimony, you make a number of proposals intended to counterbalance increased market power exercised by health insurers. As you know, Senator Kohl and I and others sent a letter to the Justice Department and the Federal Trade Commission urging them to expand their guidance on what types of "clinical integration"—joint conduct by providers—would survive scrutiny under the antitrust laws.*

   a. *I would be glad to follow up on that letter—as you suggest—but can you give us an update on the discussions providers have had with those two agencies?*

   b. *How far do you believe such guidance would go in giving providers tools to confront increasing consolidation in the health insurance market?*

Response: HAP very much appreciates Senator Kohl's, Senator Specter's and other senators' interest in promoting clinical integration between hospitals and physicians. It is, however, not the case that the goal of clinical integration is intended simply to counterbalance insurer market power; rather, it is to improve

patient care through closer collaboration that can be stymied by a complicated array of federal laws, rules and agencies. However, the situation currently facing health care providers in Pennsylvania could have the same impact as those laws and rules, if an insurer with overwhelming market power were to use the threat of antitrust litigation to prevent collaboration between hospitals and physicians.

In nearly every other sector of our economy, it is recognized that greater collaboration has the potential to foster needed improvements in quality and efficiency. To promote such collaboration, including joint negotiations on price and other terms and conditions, the Senate Judiciary Committee, followed by the entire Congress, has, on many occasions, approved legislation to ensure that collaboration wasn't stymied by antitrust enforcement or fear of antitrust enforcement. One such example is the National Cooperative Research Act of 1984, which was enacted to encourage research and development joint ventures; the legislation was so successful that it was subsequently expanded in 1993 to include production joint ventures.

Building on the work of your committee and Congress, the federal antitrust agencies have also provided guidance in a number of complicated areas of law and policy to assuage fears of unpredictable or unfathomable enforcement actions. Those agencies have issued, among other guidance materials, guidelines on horizontal mergers, international operations, licensing intellectual property, collaborations among competitors, and, of most importance to HAP, guidelines on enforcement policy in health care. The latter addresses a wide range of health care policies and practices that, prior to the issuance of guidelines, were being stymied by fear of antitrust enforcement, including inconsistent antitrust enforcement by the two separate federal antitrust agencies -- the Federal Trade Commission (FTC) and the Department of Justice's Antitrust Division (DOJ). Those guidelines also opened the door to collaboration among hospitals and physicians through clinical integration, but provided little guidance about how providers could navigate that narrow passage.

HAP's goal is to have the federal antitrust agencies issue more guidance, similar to the health care guidelines, which providers can use to better navigate this narrow passage. To that end, we have been working closely with the American Hospital Association to encourage the antitrust agencies to endorse the working paper entitled "Guidance For Clinical Integration, a Working Paper," authored by three former FTC alumni, including an award winning former Commissioner. That working paper is attached.

Following are our specific responses to the two questions:

a) Hospital representatives have met with the Chairman and every commissioner at the FTC on the subject of clinical integration. One commissioner, her staff, and other high ranking staff, were able to visit one of the premier clinical integration sites in Chicago, Illinois last year to view firsthand the remarkable progress hospitals and physicians can make in improving quality and efficiency through greater collaboration. The reaction from FTC officials has been encouraging.

   The FTC, in collaboration with DOJ, also held a one day workshop in May: Clinical Integration in Health Care: a Check-Up. The transcript of the workshop can be found online at the FTC's website. The workshop confirmed our view, and that of most hospital observers, that additional guidance from the antitrust agencies would facilitate clinical integration. For example, one provider noted that an FTC investigation of its clinical integration arrangement outlasted the tenure of two different FTC Chairmen and resulted in huge legal fees as well as costly private litigation. Another provider spoke about antitrust enforcement being the biggest concern to her arrangement.

   It was at the urging of this Committee that the federal antitrust agencies collaborated to produce the first edition of the guidelines on enforcement policy in health care. These guidelines provided a clear roadmap for providers around the country about what was and was not likely to be permitted by the agencies. Providers did not have to rely on agency speeches, opinion or business review letters or other vague assurances that required costly legal analysis and carried significant limitations; rather they could rely on a much clearer, more concise and authoritative document that addressed the issues they confronted in trying to build a more modern and efficient health care delivery system.

   We, therefore, again ask for your support in urging the agencies, particularly the FTC, to approve the same kind of useful guidance on clinical integration for providers, including those in Pennsylvania.

b) We believe that clear guidance is essential and would be useful to providers. As the remarks of the insurance representative at the FTC workshop demonstrate, there are entirely unfounded concerns by some insurers to clinical integration. This should be of great concern to the Committee and the federal agencies.

> Private parties also have the ability to threaten and bring antitrust litigation, which carries the threat of huge legal costs, treble damages and follow-on state or federal enforcement activities. Few, if any, providers can withstand that threat. However, the threat is greatly mitigated if providers have a clear statement of policy from the federal antitrust agencies on which to rely. Judges across the country respect the agencies and their command of antitrust law and policy. Being able to reference clear guidance from FTC and/or DOJ on clinical integration should bolster the resolve of providers to work together to improve care and efficiency, even in the harsh glare of insurer intimidation. The benefits for patients of greater clinical integration are clear. Guidance from the federal antitrust agencies would go a long way toward removing the roadblocks stymieing its progress. We ask for your assistance to overcome one of these roadblocks to help the providers in your state and beyond move ahead on the road to more integrated and efficient health care.

HAP and its member hospitals and health systems appreciate the committee's ongoing interest in the issue of insurer consolidation in Pennsylvania and the efforts of this committee in support of health care providers seeking clear guidance from the FTC and DOJ. Please feel free to contact me, Paula Bussard, HAP's senior vice president, policy & regulatory services, at pbussard@haponline.org or at (717) 561-5344, or Michael Strazzella, HAP's vice president, federal relations, at mstrazzella@haponline.org or at (202) 863-9287, if you require any additional information on the items included in this letter.

Sincerely,

Carolyn F. Scanlan

CAROLYN F. SCANLAN
President and Chief Executive Officer

Attachments
/pkh

c: The Honorable Arlen Specter, United States Senator

SUBMISSIONS FOR THE RECORD

Statement

of the

American Medical Association

to the

Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights
United States Senate

Re: Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription?

Presented by: Henry S. Allen, Jr., Esq.

July 31, 2008

I Opening Statement

The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on the Judiciary on consolidation in the Pennsylvania health insurance industry. We commend Chairman Kohl, Ranking Member Hatch, Senator Specter and the other members of the Subcommittee on Antitrust, Competition Policy, and Consumer Rights for your leadership in recognizing the threats that health insurer consolidations pose to the delivery of health care in Pennsylvania and across the country.

The AMA believes that competition, not consolidation, is the right prescription for health insurer markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

In Pennsylvania where health insurer entry from outside the state has been difficult and little incumbent competition exists, the potential competition that Highmark poses to Independence Blue Cross ("IBC" or "Independence") is the only market mechanism that protects patients from higher premiums. This potential competition also offers the prospect that physicians practicing in IBC's territories will have somewhere else (i.e., Highmark) to sell their services.[1] A merger would foreclose this alternative and provide the merged firm with the sort of monopsony power[2] that is depriving physicians of the ability to negotiate competitive health insurer contract terms in markets around the country. Accordingly, the AMA opposes the proposed merger of Highmark and IBC.

II. Merger to Monopoly

The market shares of Highmark and IBC are more than sufficient for the merger to be found presumptively illegal under both Section 7 of the Clayton Act (15 USC § 18) (Section 7) and the Pennsylvania Insurance Holding Companies Act("PAIHCA"). Monica Noether, PhD, a former Deputy Assistant Director of the Federal Trade Commission Bureau of Economics[3], has concluded that the merger would combine a Highmark market share of 42 percent with that of IBC's share of 30 percent, and would result in a combined entity with more than 70 percent of

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[1] See Lawrence A. Sullivan & Warren S. Grimes, The Law of Antitrust: An Integrated Handbook §11.3b-.3b1 (2000) (for a discussion of the consumer welfare benefits of potential competition).

[2] Text from: "Agenda for Joint FTC / DOJ Hearings on Health Care and Competition Law and Policy" (Washington D.C., Thursday, April 24, 2003) Available from: http://www.ftc.gov/ogc/healthcarehearings/030405hcagenda.shtm; Accessed 07/30/2008. This source defines monopsony as a "substantial market power being exercised by buyers over sellers. In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services).

[3] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report).

the fully and self-insured commercial health insurance market in the Commonwealth.[4] The resulting post-merger level of market concentration, and the increase in that market concentration caused by the merger, triggers the presumption that the merger may substantially lessen competition or tend to create a monopoly under both Section 7 and the PAIHCA.[5] Moreover, under federal antitrust law, the resulting entity's possession of a 70 percent market share also establishes a prima facie case of monopoly power, a conclusion buttressed by the substantial barriers to market entry (also documented in Dr. Noether's report).[6] In short, this proposed merger is so anticompetitive that it amounts to a merger to a monopoly.

Highmark/IBC's statement addressing the PAIHCA's competitive standard omits any discussion of entry into the market – a factor, that under the Act, may be considered in determining whether a merger has anticompetitive effect.[7] The reason for this omission is obvious. In Pennsylvania health insurance markets there has been very little in the way of new entry[8]. Health insurers that have successfully competed in other parts of the nation including Aetna, United HealthCare, and Cigna, have barely any presence in Pennsylvania. This is

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[4] *Id.* at 7.

[5] The PAIHCA at 40 P.S. § 991.1403(d)(2)(i) provides that a highly concentrated market is one in which the share of the four largest insurers is 75 percent or more of the market. In a concentrated market when an insurer with a 4 percent market share acquires one with a 4 percent share, that would constitute a prima facie violation of the act's competitive standards. *Id.* The Noether Report at Exhibit 2 documents that in a statewide Pennsylvania market, the four largest insurers possess a total market share of 86 percent. Moreover, the shares of merging firms dramatically surpasses the 4 percent. *See also* Horizontal Merger Guidelines, US Department of Justice and Federal Trade Commission at *http://www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html.*
In *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963), the U.S. Supreme Court announced a rule of presumptive illegality in the context of heavily concentrated markets. In that case, the acquiring firm held a 30 percent market share, while the acquired firm's market share was only 3 percent.

[6] *See e.g. United States v. Grinnell Corp,* 384 US 563, 571 (1966) (The existence of monopoly power may be inferred from a predominant share of the market).

[7] *See* 40 P.S. § 991.1403(d)(2)(iv).

[8] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report, 8-11).

consistent with the federal antitrust enforcement agencies' observation that national plans have been unsuccessful entering some of the Blue Cross dominant markets in recent years.[9]

Entry is difficult.[10] As the Federal Trade Commission has reported, there are significant barriers to entry in health insurance markets. These barriers include the problems of: (i) developing a health care provider network; (ii) developing sufficient business to permit the spreading of risk; and (iii) contending with established insurance companies that have built long term relationships with employers and other consumers. Because there has been little to no entry in either of Highmark's orIBC's dominant market areas, this merger would permanently eliminate their biggest potential rival.[11]

III. Highmark and IBC are Best Characterized as "Competitors"

In a failed effort to avoid a prima facie violation, Highmark/IBC assert in their "Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d)" that they do not compete in the same market that they operate in different regional markets.[12] Consequently, their economist Barry Harris, PhD claims, "[t]he consolidation does not result in any anticompetitive effects."[13] The insurance market in Pennsylvania, however, *is* regional, and thus, the merger will substantially reduce competition. IBC and Highmark are dominant in each of the alleged regionalized markets. In the absence of a merger, Highmark's

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[9] "Improving Health Care. A Dose of Competition, Federal Trade Commission and Department of Justice" (July 2004) at 8-11.
[10] *Id.*
[11] *See* Affidavit of Professor Dranove, Exhibit 1.
[12] "Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d)", at 1-2.
[13] Comments by Barry C. Harris, PhD, in the Pennsylvania Insurance Department Public Informational Hearings July, 2008.

entry as a competitor would result in a substantial deconcentration of IBC's regionalized market.[14]

Highmark has the means other than through merger to enter IBC's regional territory. As an established Blues insurer in Pennsylvania, Highmark does not face the barriers to entry confronted by other insurers. In the past, Highmark would have marketed its Blue Shield plan in IBC's territory of southeastern Pennsylvania, but for Highmark's 1996 purchase agreement with IBC. Pursuant to that agreement, Highmark exited southeastern Pennsylvania by selling interests in two plans to IBC and promising not to re-enter IBC's territories under the Blue Shield service mark for ten years.[15] That market division agreement expired around the time this consolidation was proposed. Presently, in the absence of this agreed-upon territorial restraint, Highmark is free, capable, and desirous of offering its services in the southeastern Pennsylvania territory where IBC presently sells. In fact, Highmark has previously successfully marketed its products in southeastern Pennsylvania.[16] It could easily offer products there again, using the network of physicians it already has under contract in that region. Highmark only needs to add a relatively small number of hospitals to that network. Expanding state-wide is also made easier by the presence of companies that rent networks in Pennsylvania.[17] With the strong appeal of the Blue Shield Trademark, Highmark could accomplish its CEO's stated goal of gaining state-wide

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[14] For a discussion of these factors in a merger context, *see United States v. Marine Bancorporation, Inc.*, 418 U.S. 602 (1974).
[15] December 6, 1996 Purchase Agreement between IBC and Pennsylvania Blue Shield, Section 7.2, at 10.
[16] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report, 12)
[17] For a list of these companies see Noether Report at 7.

presence[18] – a goal that is consistent with serving employers whose employees reside state-wide.[19]

Highmark's and IBC's ability to compete with each other is not altered by the status of the parties as Blue Cross/Blue Shield licensees. The Blue Cross and Blue Shield Association (BCBSA) explained in its correspondence to acting Insurance Commissioner Ario that, "Nothing in the license agreements prevents a licensee of the Blue Cross brand from using that brand to compete against a licensee of the Blue Shield brand, and visa versa within its license service area...[M]oreover, BCBSA licensed companies may compete anywhere with nonBlue branded business, and many do."[20] Accordingly, Highmark as a Blue Shield licensee can compete in IBC's territories notwithstanding IBC's status as a Blue Cross licensee. In addition, IBC would be free to compete against Highmark in western Pennsylvania using, for example, "Amerihealth HMO" as its product.

Although Highmark and IBC have engaged in an agreement to divide the market, there are reasons of principle and policy for characterizing their proposed merger as one that lessens competition or tends to create a monopoly. First, there is no meaningful difference between actual and potential competition.[21] As Areeda & Hovenkamp observe in the leading treatise on antitrust law, once a firm like Highmark is recognized as a factor "in future predictions about the market, that firm must be counted as a competitor even though that firm has not yet won its first bid or indeed has not made any bid at all."[22] Thus, the foreclosure of this future market role serves "to lessen competition." Second, a restrictive reading understates the competitive

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[18] "Talking with Ken Milani," Harrisburg, Patriot News, July 22, 2007.
[19] Dranove Affidavit, Exhibit 1.
[20] Dec. 21, 2007 correspondence from Roger G. Wilson, Senior Vice President and General Council, Blue Cross Blue Shield Association to Joel Ario, Acting Insurance Commissioner.
[21] IV Areeda & Hovenkamp, *Antitrust Law*: An *Analysis of Antitrust Principles and their Application* ¶907 (2007) (Exhibit 2) (which explains that there are good reasons for not reading the Clayton Act requirements narrowly).
[22] *Id.*

significance of mergers that, like here, occur in highly concentrated non-competitive markets.[23] Indeed, where the merger results in a market share of monopoly proportions, the merger should constitute a Section 2 offense of monopolization because it eliminates either actual or potential competition.[24]

In sum, Highmark and IBC cannot escape the anticompetitive implications of their combined market share by arguing that they are not rivals in each other's markets. IBC and Highmark are actual competitors, as best evidenced by their agreement not to compete, which was required to control the natural rivalry between them.

IV. Anticompetitive Effects of Merger in the Insurance Market Where Physicians Sell Their Services

The merger would result in a dominant health insurance company with monopsony power in insurance markets where physicians sell their services. Consequently, physicians could be forced to accept inadequate reimbursement, which would likely to lead to a reduction in the supply of physician services - in spite of the demand for such services by patients. This is particularly significant given that recent projections by the U. S. Health Resources and Services Administration already suggest an impending shortage of physicians.[25]

It is a mistake to assume that when insurers push down the cost of physician services, insurers' interests are perfectly aligned with those of consumers.[26] Because health insurer monopsonists typically are also monopolists in the output market for healthcare insurance, lower

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[23] *Id.*
[24] *Id* at ¶912(Exhibit 3).
[25] See Health Resources and Services Administration, *Physician Supply and Demand: Projections to 2020* (Oct 2006) (which projecting a shortfall of approximately 55,000 physicians in 2020); *see also* Merritt, Hawkins, et al., *Will the Last Physician in America Please Turn Off The Lights? A Look at America's Looming Doctor Shortage* (2004). (which predicts a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically beyond the current range of two to five weeks).
[26] Mark V. Pauly, "Competition in Health Insurance Markets," 51 Law & Contemp. Probs. 237 (1998).

input prices (for physician services) do not lead to lower consumer output prices (for health care insurance premiums).[27] Indeed, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers. Although compensation to physicians has been reduced, health insurance premiums have continued to increase rapidly.[28]

Clearance of this merger by the U.S. Department of Justice(DOJ) greatly concerns the AMA.[29] The Department of Justice has challenged only three of more than 400 mergers involving health insurers and managed care organizations over the past 12 years.[30] As a result, markets for third-party payors, especially commercial insurance plans, have grown increasingly concentrated. In almost every state, one of three major insurance firms is the market leader. In most of these states, Blue Cross and Blue Shield is the dominant firm. For example, in 2002, Blue Cross and Blue Shield controlled 39 percent of the Maine market; by 2006, this had grown to 63 percent.[31] The Government Accountability Office (GAO) estimates that the largest insurer in each state of the United States typically has a 43 percent share of the market for small group coverage, a 10 percent increase in less than five years.[32] Other studies indicate that in 16 states, one insurer controls over half of the market.[33] This consolidation has developed mostly through mergers and acquisitions. Studies have shown unequivocally that in this market environment,

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[27] Peter J. Hammer and William Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004). *See also Dranove Affidavit,* Exhibit I.
[28] See Testimony from "Examining Competition in Group Health Care," Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and "Health Insurer Consolidation – The Impact on Small Business," Hearing before the House Small Business Committee, 100th Cong. (Oct. 25, 2007).
[29] See Highmarks Press Release of July 17, 2008.
[30] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets* / 2007 Update, 1
[31] Robert Pear, *"Loss of Competition Is Seen in Health Insurance Industry"*, New York Times, Apr. 30, 2006, at Section 1, 131.
[32] *Id.* at Section 1, 21.
[33] James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, 23 Health Affairs 11, 13-14 (2004).

physicians across the country have virtually no bargaining power with dominant health insurers that are monopsonists.[34]

V. Why Competition Is Good

Competition is essential to the health of the free market. Competition among insurers forces them to hold the line on premiums. With average premiums exceeding $12,000 for a family plan, even a few percentage points would make a significant difference for the typical family.

Examples of the benefits of competition among Blues plans can be found in the ongoing rivalry between Highmark and Capital BlueCross. Some of the benefits have been documented in the testimony of Anita Smith, President and Chief Executive Officer of Capital BlueCross.[35] She emphasizes that the competition between Capital BlueCross and Highmark has improved efficiency, innovation, quality, and price. Such benefits have also been discussed in the press. For example, The *Philadelphia Inquirer* carried an article on June 9, 2008, entitled "What can happen if Blues Compete; In a Swath of Pa., Capital and Highmark both offer health insurance."[36] The article contrasts the marketplace for insurance in southeast Pennsylvania, where IBC has no Blue rival, with the central area of the state, where Capital and Highmark are rivals. In central Pennsylvania, the article concludes, competition for the contract prevails, thus benefiting patients and providers. Patients and physicians should also reap the benefits of Highmark's and IBC's future competition. The firms should not be allowed to merge into a monopoly.

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[34] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets* / 2007 Update, 2.
[35] Anita Smith. "Testimony before the Commonwealth of Pennsylvania Senate Banking and Insurance Committee Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (January 30, 2008). Available from: https://www.capbluecross.com/PressRoom/NewsReleases/testimony.htm ; Accessed 07/29/2008.
[36] Exhibit 4.

VI. Conclusion

The proposed merger will have anticompetitive effects in patient and physician service markets. IBC and Highmark have maintained dominant market positions for decades. There has been little to no entry by competitors into the territories they dominate. In essence, this merger represents a contractual extension of their explicit agreement not to compete. By clearing this proposed merger, the Department of Justice has demonstrated its lack of federal antitrust enforcement in health insurance markets. Accordingly, the AMA respectfully requests that this Committee urge the federal antitrust enforcement agencies to more rigorously enforce the antitrust laws with respect to future health insurer consolidations.

Exhibits to Statement

of the

American Medical Association

to the

**Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights,
United States Senate**

RE: Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription?

Presented by: Henry S. Allen, Jr., Esq.

July 31, 2008

Exhibit 1

Affidavit of Professor David Dranove

I. Qualifications

I am the Walter McNerney Distinguished Professor of Health Industry Management at the Kellogg School of Management, as well as the Director of the Center for Health Industry Market Economics and the Director of *Health at Kellogg*. I have studied health care competition for over 20 years and have published numerous books and peer reviewed papers on the topic. I am also coauthor of the popular textbook, *Economics of Strategy*, which is used by leading business schools worldwide and contains a chapter on entry that I authored. My vita is attached.

I have also studied the Pennsylvania health care market place, first in preparing an expert report in conjunction with the bankruptcy of the Allegheny Health Education and Research Foundation and more recently in conjunction with the proposed merger of Independence Blue Cross and Highmark Inc. I have also reviewed the written testimony of Dr. Monica Noether pertaining to this matter dated July 2, 2008 and entitled, "Competitive Analysis of the Proposed Consolidation between Highmark Inc. and Independence Blue Cross in the Commonwealth of Pennsylvania."

II. Valid Concerns Raised by Dr. Noether's testimony.

I find that Monica Noether's written testimony raises several valid concerns about the merger. I will focus on two: (1) Entry into the Pennsylvania health insurance market is difficult, and (2) Independence Blue Cross and Highmark are each other's best potential competitors.

Entry is Difficult

There is no disputing that Independence Blue Cross dominates the eastern Pennsylvania health insurance market, just as Highmark dominates western Pennsylvania. The fact that the two together would have over 70 percent market share statewide reflects their dominance in their respective regions. Indeed, the two plans are likely to argue that they are already monopolists in their respective regions and that this merger does not enhance their market power. This is a short-sighted argument that Dr. Noether's testimony helps to dismiss.

Even monopolists can find that their market power is limited in the long run. This is because the high prices and resulting profits enjoyed by monopolists act a siren call to entrants. Monopolists can sustain their prices and profits only if there are barriers to entry. Dr. Noether offers compelling evidence and theoretical support for the claim that there are substantial barriers to entry in the Pennsylvania health insurance market. The evidence is there for all to see – there has been little successful entry. Health insurers that have successfully competed throughout the nation, including Aetna, Humana, United Healthcare, and Cigna, have barely any presence in Pennsylvania. The theoretical support is well-understood by those who have studied health insurance markets. In addition Sections cited in Dr. Noether's report and dominant insurers can use their monopsony power to suppress the fees they pay

to providers, thereby giving them a cost advantage over potential rivals. Unfortunately for consumers, there is often insufficient competition to force the insurers to pass along these savings to consumers. I agree with Dr. Noether's claim that entry is difficult, and that neither Independence nor Highmark are likely to be disciplined by competitors such as Aetna et al.

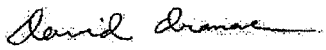
Independence and Highmark are Each Other's Best Potential Competitors

Dr. Noether's next observation is profoundly important: Independence and Highmark are best positioned to compete with each other. In the past, they have sold insurance in each other's market areas. They have managed provider networks in each other's market areas. Even today, they have corporate clients who do business statewide and might prefer the convenience of securing insurance from a single carrier. For all of these reasons, Independence and Highmark face lower barriers to entering each other's regions than do other insurers such as Aetna et al. By all rights, they should be competing with each other.

But Independence and Highmark have not entered each other's territories for a simple reason – they have had a written agreement not to do so. The agreement has now expired. This merger represents an effort by Independence and Highmark to permanently cement their agreement not to compete. This effort must not be allowed to succeed.

III. Conclusion

If the merger between Independence and Highmark is blocked, the two insurers will have a natural interest in selling insurance in each other's territories, just as they have done in the past. With statewide corporate clients, they will reestablish their provider networks, breaking down a critical entry barrier. There is no guarantee that they will blossom as competitors for one another, but if the merger goes through, it is guaranteed that competition will be stifled once and for all.



David Dranove
Walter McNerney Distinguished Professor of Health Industry Management
Northwestern University

July 14, 2008

Exhibit 2

Antitrust Law Para. 907

ANTITRUST LAW
AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION

VOLUME 4

PART TWO - Market Structure Issues

CHAPTER 9 - Mergers: Generally and Horizontal

9A - General Guides to Interpretation

Antitrust Law Para. 907

LENGTH: 980 words

Paragraph 907 - Meaning and Context of "Lessen Competition" Standard

TEXT:
Section 7 of the Clayton Act requires proof that the effect of a merger may be substantially to "lessen competition." On its face this language would appear to require a showing that a market has become or may become less competitive as a result of a merger than it had been before the merger occurred. The language might also be interpreted to mean that a merger that simply preserves the status quo, forestalling future increases in competition, does not meet the statutory standard. Or, as another alternative, it might suggest that if a market is already performing noncompetitively, a merger that produces the result that it continues to perform noncompetitively does not "lessen competition." After all, the market was not competitive before the merger, and it is not competitive after.

But there are good reasons for not reading the Clayton Act requirement that narrowly. First of all, analogous language in § 2 of the Sherman Act has not yielded so restrictive an interpretation. That statute condemns every person "who shall monopolize, or attempt to monopolize" a relevant part of commerce. n1 The word "monopolize" quite clearly refers to the act of creating a monopoly--that is, of acquiring all of the business in a market with the result that the market is no longer competitive. Nevertheless, the Supreme Court has made clear that simply *maintaining* a monopoly by anticompetitive means also constitutes monopolization. n2 For example, the dominant firm with a 100 percent market share that uses an improperly brought patent infringement suit in order to exclude a nascent rival unlawfully "monopolizes" the market--even though the firm's market share was 100 percent before the exclusionary act and 100 percent thereafter.

But there are also reasons of principle and policy for reading § 7 less restrictively. First, the restrictive reading greatly and improperly exaggerates the difference between **actual and**

potential competition. So-called **"potential" competition** is competition "for" the market, while **"actual"** competition is said to be competition "in" the market. But insofar as antitrust policy is concerned, both kinds of competition can be equally **"actual."**

Consider this relatively clear case. The market for a certain type of aircraft operates by competitive bidding between two sellers, each of whom has been making approximately 50 percent of the sales. Now, however, a firm that previously made a different type of aircraft has begun developing facilities for this type as well, and promises to be a bidder on future transactions. At that point, however, one of the incumbent firms acquires this firm, with the result that the market continues to have two bidders instead of expanding to three, which we assume would be more competitive.

It should be clear that this acquisition has "lessened competition," even though a superficial analysis would say that it merely "maintained" competition, or prevented competition from increasing. Once the presence of the third firm became a factor in future predictions about the market, that firm must be counted as a competitor, even though that firm has not yet won its first bid, or indeed, has not yet made any bid at all.

Second, the restrictive reading understates the competitive significance of mergers in markets that are already performing poorly. To illustrate, we give two examples--one in which the firms are be-having oligopolistically before a merger occurs and another in which they have formed an explicit but secret cartel.

In the first situation, suppose that a market contains five firms that are involved in a successful noncooperative oligopoly. n3 Now a merger reduces the players in that market from five to four. The orthodox theory of noncooperative oligopoly shows that, other things remaining equal, as the number of participants in the oligopoly decreases, output decreases and price increases. n4 Thus a merger in such a market can be said to "lessen competition" notwithstanding that competition was not in very good health even before the merger occurred.

In the second situation, suppose that the five firms in a market have organized an explicit but secret cartel. Unlike the noncooperative oligopoly, the organized cartel seeks to establish the same output and price that a single-firm monopolist would set, and this output and price do not vary with the number of cartel members. n5 Under the pure theory of collusion, therefore, a change from a perfectly functioning cartel of five members to a perfectly functioning cartel of four members would have absolutely no impact on either output or price in the affected market.

The operative words in the previous statement are "perfectly functioning." In reality no cartel functions perfectly, and the number and nature of the individual participants contribute much to the imperfections. The more members a cartel has, the greater the difficulty of establishing a consensus on output and price, detecting and punishing cheating, preventing outright defections, and keeping the cartel secret from antitrust authorities. n6 Further, at least some mergers in industries subject to collusion may be designed to rid the market of a "maverick" firm that had previously refused to abide by the cartel's agreement on output and price. n7 As a result, any merger that reduces the number of cartel members by one presumptively meets the "lessen competition" standard even though we might presume that the price and output of a "perfectly functioning" cartel remain the same as the number of cartel members is reduced.

FOOTNOTES:
n1 15 U.S.C. § 2.

n2 E.g., *Eastman Kodak Co. v. Image Tech. Serv.*, 504 U.S. 451, 482 (1992) (speaking of monopolization as "willful acquisition or maintenance" of monopoly power); *Otter Tail Power*

Co. v. United States, 410 U.S. 366 (1972) (litigation for anticompetitive purposes could have been unlawful attempt to maintain monopoly power); *United States v. Grinnell Corp.*, 384 U.S. 563, 570 (1966) (maintenance of monopoly power by exclusionary conduct unlawful).

n3 A "noncooperative" oligopoly is one in which each firm supposedly maximizes its own profits by equating its marginal cost and marginal revenue on the assumption that other firms will hold their output constant. See P404b1 (rev. ed.).

n4 Ibid.

n5 See PP404b2, 405 (rev. ed.).

n6 See P405b (rev. ed.).

n7 See P944c3 (rev. ed.).

Exhibit 3

Antitrust Law Para. 912

ANTITRUST LAW
AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION

VOLUME 4

PART TWO - Market Structure Issues

CHAPTER 9 - Mergers: Generally and Horizontal

9B - Antitrust Concern with Horizontal Mergers

9B-1 - Mergers Facilitating Single Firm Exercises of Market Power

Antitrust Law Para. 912

LENGTH: 1144 words

Paragraph 912 - Monopolist's or Dominant Firm's Acquisition of Nascent Rival; **Potential Competition** Merger Distinguished

TEXT:

912a. Generally. The acquisition by an already dominant firm of a new or nascent rival can be just as anticompetitive as a merger to monopoly. If the rival has already made its first sale in the monopolist's market the merger is clearly "horizontal." If the rival has not yet made its first sale, the tendency is to call the acquisition a **"potential competition"** or nonhorizontal merger. n1 But the distinction between **"actual" and "potential" competition** is readily exaggerated. For example, a firm that has submitted bids against the dominant firm but lost is clearly an **"actual"** competitor, perhaps even forcing the dominant firm to lower its bid in the face of a rival bidder. n2 But even the firm that is preparing to make its first bid or its first sale must be counted as an **"actual"** rival once the entry decision has been made.

Acquisition of such a rival preserves the dominant firm's status, at least until another nascent rival appears on the scene. In most such cases we do not believe it is worthwhile to ascertain the number of rivals or the likelihood or time period in which another nascent rival will appear. The important point is that the acquisition eliminates an important route by which competition could have increased in the immediate future. It thus bears a very strong presumption of illegality that should rarely be defeated.

912b. Differences between Clayton and Sherman Act standards. Section 7 of the Clayton Act condemns mergers that may substantially *lessen* competition. By contrast, § 2 of the Sherman Act reaches acts that merely "maintain" a monopoly. n3 While the distinction is

easily exaggerated, it should not be lost. Some mergers with potential rivals might be thought not to "lessen" competition at all because they neither reduce the number of rivals in the market nor increase the market share of any firm. n4 But when the dominant firm in the market has a market share satisfying the § 2 standards for monopoly or attempt, a "lessening" of competition is not essential to illegality. Such a merger tends to maintain a monopoly by cutting off an avenue of future competition before it has had a chance to develop.

912c. Possible efficiencies defense. n5 In order for a dominant firm to defend its acquisition of a nascent rival on the basis of claimed efficiencies, it would have to show provable efficiencies that could not be brought about by means other than the merger (i.e., "merger-specific" efficiencies) and that do not result from the creation of a monopoly. n6 But provable merger-specific efficiencies from the acquisition of a nascent firm should be quite unusual; in most circumstances the dominant firm could readily duplicate anything that the nascent firm has to offer.

The exceptions are (1) when the nascent firm has a new technology protected by the intellectual property laws that the dominant firm can acquire only by acquiring the firm itself; or (2) when the nascent firm has a substantial position in a different market and the efficiencies result either in that market or else from the combination of ownership controlling the two markets.

On the first, suppose that the dominant firm uses a process that costs $ 6.00 per unit, but that a tiny rival who has not yet made its first sale in the market develops and patents equally good technology costing only $ 4.00 per unit. Not being able to license the technology, the dominant firm launches a hostile takeover of the tiny firm itself. We would treat this as little different in principle from a patent monopolist's acquisition of an exclusive right in a competing patent at the center of its power, n7 and thus as presumptively unlawful. n8 To be sure, the acquisition permits the dominant firm to reduce its production costs, but it does so by eliminating competition between the production alternatives. The most likely reason that this market has a chance of becoming competitive is that the nascent firm has technology that will enable it to compete successfully with the dominant firm; nothing prevents the dominant firm from (1) attempting to acquire a nonexclusive license from the nascent firm n9 or (2) if that effort fails, to develop its own alternative technology.

On the second situation noted above, suppose that a firm is nascent in the dominant firm's market but has a significant position elsewhere, and that combining the two firms produces certain efficiencies. For example, in the *El Paso Natural Gas* case n10 the acquiring firm had significant gas fields in Texas, while Pacific Northwest, the acquired firm, had fields in the northern United States and Canada. Although Pacific Northwest had made bids to southern California purchasers, it had not yet won any bids and thus was not an **actual** seller there. In such a case the union of firms could produce significant offsetting efficiencies in the other market. n11 Of course, this raises the problem of the extent to which efficiencies in one market justify anticompetitive results in a different market. n12

912d. Nonexclusive license or compulsory licensing as solution. n13 The discussion of patent acquisitions by monopolists shows that concerns about anticompetitive effects from the dominant firm's acquisition of technology are satisfied by requiring that the dominant firm obtain only a nonexclusive license. n14 The problem is not materially different when the dominant firm seeks to acquire the tiny firm itself rather than its patents or other intellectual property. First, while technology acquisitions can certainly promote efficiencies, a nonexclusive right does so just as well as an exclusive one. Second, if the main concern is that the acquisition threatens to eliminate a rival technology, that threat is taken care of by the nonexclusive license or else by the acquirer's willingness to license all others without royalty--that is, to place the acquired technology in the public domain. To be sure, this may often mean that the acquisition is not worth nearly as much to the acquiring firm, but if the

principal value of the acquisition is the dominant firm's maintenance of its technological hegemony then the only alternative is outright condemnation. n15

FOOTNOTES:
n1 See P701d (rev. ed.) (acquisition of potential rival as Sherman § 2 violation); and Ch. 11B-2 (**potential competition** merger as Clayton § 7 violation).

n2 See, e.g., *United States v. El Paso Nat. Gas Co.*, 376 U.S. 651 (1964); and P1117a.

n3 See P907 (rev. ed.), which cites § 2 cases.

n4 This is particularly true of the "**actual** potential entrant" doctrine. See P1121.

n5 On the efficiencies defense generally, see Ch. 9E (rev. ed.).

n6 Cf. the 1997 revised statement on efficiencies to the 1992 Horizontal Merger Guidelines, § 4.0: "cognizable efficiencies are merger-specific efficiencies that . . . do not arise from anticompetitive reductions in output or service." These Guidelines are reprinted as Appendix A in the Annual Supplement.

n7 See P707a,b (rev. ed.).

n8 As P707d (rev. ed.) notes, however, an acquisition of a nonexclusive right would be legal.

n9 See Pd.

n10 See note 2.

n11 This might occur, for example, if El Paso had substantial facilities in the northern United States as well, and joint operation of the firms' facilities would have reduced costs there. These were not the facts of the **actual** case.

n12 See P972 (rev. ed.).

n13 The same issue arises when the underlying concern is that a large firm's acquisition of a smaller rival's technology might facilitate collusion by forestalling new competition. See P927d3 (rev. ed.).

n14 See P707d (rev. ed.).

n15 See, e.g., *United States v. Baroid Corp.*, 59 Fed. Reg. 2610 (1994) (consent decree conditioning acquisition by large firm of competing technology on the granting of licenses to others); *Westinghouse Elect. Corp.*, 54 Fed. Reg. 8839 (1989) (similar).

Exhibit 4

Posted on Mon, Jun. 9, 2008

What can happen if Blues compete

In a swath of Pa., Capital and Highmark both offer health insurance. Users have varied opinions.

By Jane M. Von Bergen
Inquirer Staff Writer

When public hearings on the proposed merger of the state's two largest health insurers begin next month, speakers opposed to the deal are sure to complain that a combination of Independence Blue Cross and Highmark Inc. would quash competition.

In the Philadelphia marketplace, Independence Blue Cross dominates its competitors, commanding a lion's share of the business, though both it and Highmark say they need to get bigger to fend off national insurers such as Aetna Inc., which is gaining market share.

Independence has no Blue rival in the region - important in a state such as Pennsylvania, where loyalty to the "Blue" brand is strong.

However, in a broad swath from Harrisburg to Easton, two Blues insurers, Harrisburg's Capital Blue Cross and Pittsburgh's Highmark, are rivals. Besides the Blues, other insurers also have a noticeable presence. Competition not only exists, it is fierce.

And that's just the way car dealer Greg Kelly likes it.

Right now, Kelly has a bid in his office from Capital that would save him $25,000 to $30,000 on the annual premium he now pays Highmark to cover 180 employees of Kelly Automotive Group's seven Lehigh Valley car dealerships.

"We have an offer in hand from Capital, but we'll go back to Highmark and see if they can match it," he said. Kelly had been with Capital before, but left it four years ago when Highmark produced a better bid.

"Capital's margins are tight and Highmark keeps them honest," said Kelly's broker, Jonathan P. Warner, of JP Warner Associates Inc., which has offices in the Lehigh Valley and in Wayne.

Now it's contract-renewal time.

"We're getting the best of both worlds," Kelly said. "Can you imagine that happening if there was just one Blue? It would never happen."

In 2007, Capital had a million subscribers enrolled and Highmark had 800,000, according to their annual reports. Capital estimates that the two Blues have two-thirds of the market.

While other insurers, including Aetna and, in the Lehigh Valley, the home-grown Valley Preferred, help create a robust marketplace, the two Blues compete neck-and-neck for the bulk of business.

The Blue rivalry had its roots in the 1996 birth of Highmark, the product of a merger between Blue Cross of Western Pennsylvania and Blue Shield, a statewide insurer for doctor bills.

For decades before the merger, Blue Cross of Western Pennsylvania, Capital Blue Cross, Independence Blue Cross and Blue Cross of Northeastern Pennsylvania all had the same joint operating relationship with Blue Shield. The Blue Cross insurers covered hospital stays; Blue Shield was the insurer for doctor bills.

Several years after the merger, Highmark moved to acquire Capital. But Capital rejected the terms. Highmark ended the relationship, entering what had been Capital's territory as a competitor.

The split began on Sept. 10, 2001, and became final in April 2002.

Both insurers had to scramble to draft contracts with providers. Highmark needed the region's 40 hospitals, which already had deals with Capital. Capital had to sign up the 13,000 doctors and other professionals already affiliated with Highmark.

"This wasn't just competition," said Anita Smith, Capital's president. "This was piranhas - don't-put-your-hands-in-the-water competition."

To Robert Stover, the warfare looked like opportunity. Stover is the chief executive of Medical Associates of the Lehigh Valley, a group of 50 family doctors in 22 locations who together care for 130,000 patients, about a fifth of the total in the region, he said.

His organization negotiates insurance reimbursements for the doctors based on price and service.

"There seemed to be a large stalemate" with Highmark, Stover said. When Highmark's predecessor, Blue Shield, had most of the doctors in the state under contract, there would have been little he could do.

But, as talks continued, Stover prepared an advertisement to run in the papers explaining to Lehigh Valley residents why their doctors would no longer accept Highmark insurance.

"We had a final meeting the day before the advertisement was to run and we showed them the ad," Stover said. "They were horrified." The situation was resolved.

"Now we have a stable marketplace," he said. "There is give and take. They [all] know we can drop them. If you have no ability or inclination to drop a contract, you have no bargaining power."

The rivalry also looked like an opportunity to Elliot Sussman, the chief executive of the Lehigh Valley Hospital and Health Network, one of the area's largest. With two major insurers vying to sign a contract, he was able to punish a third, Aetna, for not meeting the network's terms on reimbursement rates.

Aetna had been an important insurer in the Lehigh Valley. But from 2002 until 2007, the network would not accept Aetna. "It took a little chutzpah to do it," Sussman said. "We were able to do that because of competition in the marketplace."

There are other advantages, Sussman said. When the network decided to expand the outreach of a dental clinic at its hospital in Allentown, Sussman went to the insurers, hat in hand, to fund a $900,000 mobile clinic. Capital ponied up $250,000, celebrating the occasion at a news conference attended by children at a local elementary school.

Highmark also has contributed, donating $100,000 in 2004 for a hospital-run osteoporosis prevention and education program.

Kitty Gallagher had hoped that competition would help her shake loose some key bargaining information.

As president of the Lehigh Valley Business Coalition on Healthcare, she negotiates health insurance for the 32,000 employees and family members of the Lehigh Valley's major employers, including Mack Truck Inc. and PP&L Corp.

"When the divorce first happened, I thought it was very positive," Gallagher said.

Most of her companies self-insure, meaning they pay claims directly. To service them, the insurers negotiate fee schedules with the hospitals and doctors, handle the claims and provide other services, such as disease-management programs.

Gallagher wanted to know what the insurers paid the doctors and hospitals. "We tried to play them all off against each other. I can't tell you how hard we fought toe-to-toe on it," she said. "They held us off."

Without that information, she still negotiates, but she would like to see more transparency.

Family practitioner Samuel Bub, of Emmaus, said competition was good in theory.

"But for the average physician in a small practice, we need to be part of both plans to capture the patients," he said. "A small group is in no position to bargain with either one of them.

"On a day-to-day basis, my focus is to see the patients."

Contact staff writer Jane M. Von Bergen at 215-854-2769 or jvonbergen@phillynews.com.

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Testimony of David Balto
Senior Fellow
Center for American Progress

Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Rights

"Consolidation in The Pennsylvania Health Insurance Industry: The Right Prescription?"

July 31, 2008

I appreciate the privilege to testify before you today about the anticompetitive effects that likely will result from the proposed acquisition of Independence Blue Cross by Highmark, Inc. As I explain in my testimony, the merger will pose a significant threat to competition in the Southeastern Pennsylvania health insurance market by eliminating Highmark as a potential entrant into the market. History has demonstrated that Highmark has the incentive and ability to enter into adjacent markets and that competition has benefitted employers, consumers, and providers. The antitrust laws protect not only ongoing competition, but also the potential competition that would exist but for this merger. Simply put, in answer to the question posed by this hearing, the right prescription for this market is to prohibit this merger.[1]

I have practiced antitrust law for over 20 years, primarily in the federal antitrust enforcement agencies: the Antitrust Division of the Department of Justice and the Federal Trade Commission. At the FTC in the 1990s I was attorney advisor to Chairman Robert Pitofsky and directed the Policy shop of the Bureau of Competition. In private practice and in government service I assisted in the litigation of numerous merger cases including Staples/Office Depot and Heinz/Beechnut. In addition, I regularly represent parties that oppose mergers before the Antitrust Division and the Federal Trade Commission. Most recently, I led a coalition of consumer groups, government entities, unions, and health care providers that opposed United Healthcare's acquisition of Sierra Health Services. My testimony today is based on my years of reviewing proposed mergers as a government enforcer and providing advice and analysis of mergers as a private practitioner.

The alarming trend of Health Insurance Consolidation

Let me begin with some observations about the dramatic trend of health insurer concentration and the alarming lack of antitrust enforcement. In the past seven years an unabated flood of health insurance mergers has led to highly concentrated markets, higher premiums, and lower reimbursement. Skyrocketing premiums have put insurance

[1] My testimony is also supported by the American Antitrust Institute, the Consumer Federation of America, the National Association for the Self Employed, and the U.S. Public Interest Research Group. See attachment for a description of each organization.

out of reach for millions of consumers and thousands of small businesses and the number of uninsured Americans has increased to critical levels: over 47 million, or one out of seven Americans under age 65.[2] As consumers have suffered from egregious deceptive and anticompetitive conduct by insurance companies, those companies have recorded record profits. The problems presented could not be starker or have a more severe impact on consumers.

In the past decade there have been over 400 health insurer mergers and in only two cases has the Department of Justice brought any enforcement action. Besides mergers, the Justice Department has not brought any cases challenging anticompetitive or exclusionary conduct by health insurers, even though numerous private plaintiffs and state attorneys general have challenged this type of conduct. In effect, the insurance companies have gained a newly found "antitrust immunity."

The lack of health insurance merger and nonmerger enforcement is criticized in a forthcoming report by the American Antitrust Institute on antitrust enforcement. They observe:

> The priorities of the health care enforcement agenda need to be realigned to areas with the greatest impact on consumers. Unlike in prior administrations, there is a significant imbalance in enforcement priorities between anticompetitive activity by health insurance companies and healthcare providers. In the seven years of the Bush II administration, all non-merger enforcement actions have involved health care providers, with no enforcement involving health insurers.

The consequences of lax antitrust health insurance enforcement for consumers are clear. The American Medical Association reports that 95 percent of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20 percent since 2000. These mergers have not led to benefits for consumers: instead premiums have skyrocketed, increasing over 87 percent over the past six years. Small employers have been particularly harmed by skyrocketing premiums and they increasingly find it difficult to offer health insurance coverage.[3] Patient care has been compromised by the over-aggressive efforts of managed care, and the number of uninsured Americans has reached record levels.

A vital component to assuring the competitive marketplace is protecting the ability of consumers to choose between alternatives. Antitrust enforcement against anticompetitive mergers and exclusionary conduct is essential to a competitive marketplace. This unprecedented level of concentration and the lack of antitrust enforcement pose serious

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[2] *See* "Wrong Direction: One out of Three Americans are Uninsured" (Families USA 2007).

[3] Prepared Remarks of Mr. Robert Hughes, President, The National Association for the Self-Employed before the House Small Business Committee Hearings on Health Insurer Consolidation- The Impact on Small Business (Oct. 25, 2007) (Observing that small businesses suffer greater premium increases than large companies and have greater difficulty providing health insurance to their employees).

policy and health care concerns. As Vermont Sen. Patrick Leahy observed in hearings before the Senate Judiciary Committee in 2006 on health insurance consolidation:

> A concentrated market does reduce competition and puts control in the hands of only a few powerful players. Consumers—in this case patients—are ultimately the ones who suffer from this concentration. As consumers of health care services, we suffer in the form of higher prices and fewer choices.[4]

Competition matters: A recent study noted that insurance premiums are 12 percent lower in those markets in which there is comparatively a lower level of concentration than in more concentrated markets.[5]

Congress is currently grappling with the severe problems of the uninsured. The number of uninsured has increased by over 17 million since 2001 and now amounts to over 47 million Americans.
There is a direct relationship between the insurance consolidation and the anticompetitive conduct engaged in by health insurers, and the increasing problem of the uninsured in the United States. Increased concentration and a lack of enforcement have led to skyrocketing premiums, higher deductibles, and higher co-pays. The most severe problems occur simply when employers or employees can no longer afford insurance. Increasingly employers have been forced to scale down insurance or drop insurance altogether. Thus, the number of uninsured individuals has hit a record level. The lack of enforcement has created an environment where the insurance companies act as if they are immune from antitrust scrutiny. This must be reversed.

Perhaps the most striking example is the DOJ's modest enforcement action that permitted the nation's largest insurer United Healthcare Group to acquire Sierra Health Services, the dominant insurance company in Las Vegas. The merger increased United's market share from 14 percent to 56 percent in Las Vegas. After an 11-month investigation of a merger posing an unprecedented level of concentration in perhaps the most vulnerable health care market in the United States, the DOJ chose a modest remedy on a single line of business. Even though the DOJ reviewed millions of pages of documents and conducted over 100 interviews, it failed to address the significant loss of competition in both the sale of commercial insurance and purchase of physician services markets. Ultimately, the Nevada attorney general had to step in and file a separate case in federal court with a 61-page consent order to address some, but not all, of the concerns ignored by the DOJ.[6] However both actions permit United to secure over a 56 percent market

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[4] Statement of Senator Patrick Leahy, Hearing on "Examining Competition in Group Health Care" U.S. Senate Committee on the Judiciary (Sept. 6, 2006).
[5] Testimony of Diane Holder, President and CEO of the University of Pittsburgh Medical Center before the Pennsylvania Insurance Department at 8. ("The health insurance market is no different than any other market in the U.S. An examination of data from 31 states across the country shows the average cost of health insurance premiums in states with higher than average levels of competition are 12% lower than premiums in states with lower than average competitive levels.").
[6] *State of Nevada v. UnitedHealth Group Inc. and Sierra Health Services, Inc.,* Case No. 2:08-cv-00233 (D. NV. 2008). The 61-page Nevada consent order also compelled the divestiture of United's Medicare Advantage business; but went far beyond the DOJ action and addressed competitive concerns involving

share in the Las Vegas commercial health insurance market, positioning it as a firm that can increase premiums, reduce service, and reduce reimbursement to hospitals and physicians leading to a lower level of health care in the fragile Las Vegas health care market.

The proposed merger faced almost unprecedented opposition from government entities, community groups, public interest groups, healthcare alliances, physicians, nurses, employers, and state legislators.[7] After the proposed consent decree was filed by the DOJ, numerous groups including the American Medical Association and other physician groups, the Service Employees International Union, the Honorable Nydia M. Velazquez, Chairwoman, United States House of Representatives Committee on Small Business, and the Honorable Chris Giunchigliani, Commissioner, Board of Commissioners of Clark County, Nevada filed comments under the Tunney Act objecting that the DOJ action was inadequate because:

- It failed to secure relief in the commercial insurance market
- It failed to secure relief in the market for the purchase of physician services
- The action was inconsistent with past DOJ policy
- The merger will lead to lower quality of health care by reducing reimbursement to physicians and hospitals

One of the critical issues raised in the comments was the potential for United to exercise monopsony power, depressing the level of reimbursement for hospitals and physicians. The DOJ's failure to bring an enforcement action based on provider issues seemed inconsistent with past precedent. As representatives of consumers, we recognize the important need to manage health care costs. However, giving insurers greater buying power is not necessarily beneficial for consumers. Health insurers with monopsony power may profit from pushing provider prices "too low" so that consumers do not receive an adequate level of service and quality.[8] As the AMA observed:

> [H]ealth insurers are not true fiduciaries for insurance subscribers. Plan sponsors may have a limited concern over the product based on the cost of the insurance, and not the quality of care. Furthermore, health coverage plans operate in the

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physicians, Clark County, the University Medical Center and the delivery of healthcare to underserved populations. For example, on physician-related concerns, the Nevada decree enjoins the merging parties from enforcing all products and most favored nations clauses in their contracts for a period of two years, prohibits the merging parties from entering into exclusive contracts with physicians for a period of two years, and creates a Physicians Council for the purpose of addressing the relations between United and physicians, among other relief. On commercial insurance concerns, the Nevada decree prevented United from acquiring the largest provider of "administrative services" for self-insured employers.

[7] For example, *see* Jennifer Robison, *MERGERS AND ACQUISITIONS: Buyout sessions conclude.* Las Vegas Rev. J. (July 28, 2007). Twenty-four organizations and individuals ranging from doctors and nurses to business owners, spoke out in opposition to the merger at the Nevada Dept. of Ins. hearings held July 2007. In addition, there was strong opposition to the merger by consumer groups including Consumers Federation of American and the American Antitrust Institute. *See* testimony of David A. Balto before the Nevada Commissioner of Insurance on the UnitedHealth Group proposed acquisition of Sierra Health Services, Inc. (July 27, 2007).

[8] Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1998).

> interest of a group, not in the best interest of individual patients. Consequently, health insurers can increase profits by reducing the level of service and denying medical procedures that physicians would normally perform based on professional judgment. In the absence of competition among insurers, patients are more likely to pay for these procedures out-of-pocket or forego them entirely. Ultimately, the creation of monopsony power from a merger can adversely impact both the quantity and quality of health care.[9]

These Tunney Act filings were voluminous and the commentators' arguments were supported with a broad range of evidence that included surveys and expert testimony. Unfortunately, the DOJ refused to respond to the concerns about commercial insurance or provider issues raised by the commentators suggesting that "[b]ecause the United States did not allege that the United's acquisition of Sierra would cause harm in additional markets, it is not appropriate for the Court to seek to determine whether the acquisition will cause anticompetitive harm in such markets." As described in the AMA comment that argument was inconsistent with Congress' intent in amending the Tunney Act. Moreover, the DOJ's silence is simply inconsistent with its policy of articulating reasons for not bringing enforcement actions.[10] Simply, all consumers, nurses, doctors, and health care providers deserve to have their questions answered by the chief antitrust enforcement official about why this merger did not pose substantial competitive concerns.

The proposed Highmark/Independence Blue Cross merger

Today's hearing evaluates the proposed Highmark/Independence Blue Cross merger. The merger will combine the two largest health insurers in Pennsylvania and create a firm with over 8 million beneficiaries and $23 billion in revenue. The merger will create the largest insurer in Pennsylvania with over a 73 percent market share, far outdistancing the next closest competitor. Highmark is based in western Pennsylvania and IBC is based in southeastern Pennsylvania. Highmark also has operations in central Pennsylvania and has an ownership interest in Northeastern Blue Cross.

The most straightforward concerns are raised when firms are direct competitors. In this case, there is some evidence that Highmark and IBC compete directly, even though the commercial business of each appears geographically dispersed:

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[9] Comments of the Amer. Med. Ass'n. on the Proposed Consent Order, *United States of America v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, Case No. 1:08-cv-00322 (D.D.C. 2008). at 9.

[10] Providing clarity on the reasons not to bring an enforcement action in these markets is consistent with the Division's policy on "Issuance of Public Statements Upon Closing of Investigations," *available at* http://www.usdoj.gov/atr/public/guidelines/201888.htm (factors that will lead to the issuance of a closing statement include "whether the matter has received substantial publicity [and] the value to the public in receiving information regarding the reasons for non-enforcement (including public trust in the Department's enforcement, and the value of the analysis for other enforcers, businesses and consumers)"). DOJ has issued closing statements in other health insurance mergers. *See* DOJ Press Release No. 04-497 (statement closing investigation of UnitedHealth's acquisition of Oxford Health Plans), a*vailable at* http://www.usdoj.gov/atr/public/press_release/2004/204674.htm.

- Both firms compete for certain Medicaid programs. In the Medicaid managed care market the parties admit that in the Lehigh/Capital zone, Highmark and IBC subsidiaries are two of the three competitors with a market share of over 77 percent.[11] These two firms are also direct competitors in the voluntary Medicaid managed care program in several counties.
- Many employers in southeastern Pennsylvania must provide coverage in central Pennsylvania because their employees commute from central Pennsylvania.

The parties attempt to justify their merger based on two arguments: first, they argue that since there is no direct geographic overlap there is no loss in competition. Second, the parties suggest that there will be very substantial cost savings from the merger, which the parties have committed to pass on in the form of benefits for the community.

The significant loss of potential competition will harm consumers

It is a settled principle of antitrust law and economics that potential entrants can constrain the ability of actual competitors to exercise market power. Consequently, mergers and other consolidations of current competitors and potential entrants that eliminate the procompetitive effects of potential competition can harm competition — particularly if the potential entrant is one of a relatively small number of firms with the capacity and incentive to enter the market, the market is concentrated, and high barriers to entry are likely to deter other new entrants. In appropriate circumstances, the courts have enjoined such consolidations to preserve the procompetitive benefits of potential competition.[12]

> As Justice Potter Stewart observed over a quarter of a century ago:
> The central message of the Sherman Act is that a business entity must find new customers and higher profits through internal expansion — that is, by competing successfully rather than by arranging treaties with its competitors.[13]

As the Supreme Court observed in *United States v. Penn-Olin* "[t]he existence of an aggressive, well equipped and well financed corporation engaged in the same or related lines of commerce waiting anxiously to enter an oligopolistic market would be a substantial incentive to competition which cannot be underestimated."[14]

One example where a merger was challenged, in part, because of potential competition concerns was Staples' proposed acquisition of Office Depot that was successfully

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[11] Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d).
[12] *Yamaha Motor Co., Ltd. v. Federal Trade Commission*, 657 F.2d 971 (1981), *cert. den'd* 452 U.S. 915 (1982); *see also United States v. Marine Bancorporation*, 418 U.S. 602 (1974), *Engine Specialties, Inc. v. Bombardier Ltd*, 605 F.2d 1 (1979).
[13] *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 116 (1975).
[14] *United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 174 (1964).

challenged by the FTC in 1996.[15] The merger focused on the 30 or so markets where the firms competed head to head. But both firms were successful and expanding and based on their past history it was reasonable for them to invade each other's territories. The court enjoined the merger both because of the potential loss of actual and potential competition. As to potential competition it observed:

> Since prices are significantly lower in markets where Staples and Office Depot compete, eliminating this competition with one another would free the parties to charge higher prices in those markets, especially those in which the combined entity would be the sole office superstore. In addition, allowing the defendants to merge would eliminate significant future competition. Absent the merger, firms are likely, and in fact have planned, to enter more of each other's markets, leading to a deconcentration of the market and, therefore, increased competition between the superstores.[16]

The *Staples* decision offers an important lesson for this hearing. Within a few years both firms grew sufficiently through internal expansion to achieve most, it not all of the efficiencies sought by proposed merger.

Under the law there are two separate theories of potential competition: "perceived potential competition" theory and the "actual potential competition" theory. When the law speaks of "perceived potential competition," the concern is that competition will be harmed by the elimination of a firm that currently constrains anticompetitive conduct because it is a potential entrant in the market. Elimination of the potential entrant through merger may eliminate that threat, enabling the remaining firms to raise prices, reduce output or lower service. When the law speaks of "actual potential competition" the concern is that competition will be harmed by eliminating a firm through merger that but for the merger would independently enter the market. The injury to competition stems from this preemption of actual entry that would lead to a more competitive market. Today I will focus on the actual potential competition theory.

There are several reasons why there are significant concerns over the loss of potential competition from the proposed merger. First, IBC and Highmark's predecessors used to compete in southeastern Pennsylvania prior to a 1996 acquisition. As part of that acquisition IBC and Highmark entered into a 10-year "truce" not to invade each other's territories. Not surprisingly this transaction was announced within a few weeks after the 10-year truce expired. Perhaps part of the motivation for the transaction was to make sure that competition did not break out.

As Anita Smith, the President and CEO of Capital Blue Cross testified before the Pennsylvania Senate Banking and Insurance Committee:

> Highmark and IBC do not compete because they agreed not to compete in 1996. And now that agreement is expired. If they wanted, they could

[15] *FTC v. Staples, Inc.*, 970 F. Supp. 1066 (D.D.C. 1997).
[16] *Id.* at 1082.

> compete right now. Today. We could have vibrant competition between these companies in southeastern Pennsylvania this very minute. Their merger is their effort to make permanent their agreement not to compete. And they want you to help them do it.[17]

Often making a prediction about likely entry and the impact of that entry can be a difficult process. This is not be such a case. There is compelling evidence that Highmark has the incentive and ability to enter and this entry would improve competition in the market. First, Highmark's CEO has been explicit that his goal is to create a single firm to provide services statewide and become the sole Blue Cross firm in the state.[18]

Second, the procompetitive impact of entry seems indisputable. Here history provides a powerful example of both the likelihood and impact of Highmark's entry into southeastern Pennsylvania. In 2002, Highmark severed a joint operating agreement with Capitol Blue Cross and invaded its territory of Central Pennsylvania and the Lehigh Valley. Within six years Highmark has secured over 33% of the market. Highmark's expansion resulted in greater competition, lower premiums and improved service and CBC and Highmark battled head-to-head for subscribers, employers, and providers.[19]

The DOJ/FTC *Merger Guidelines* identify three threshold tests in deciding whether to challenge a transaction based on injury to potential competition. The agencies are "unlikely to challenge a potential competition merger" unless (1) the acquired firm's market is highly concentrated (HHI above 1,800); (2) entry barriers in that market are high, so that firms without specific entry advantages cannot be expected to enter; and (3) the acquiring firm's entry advantage is possessed by fewer than three firms. The *Guidelines* describe the effects of actual potential competition as ones where "the merger could result in a lost opportunity for improvement in market performance resulting from the addition of a significant competitor."[20] Each of these factors seem clearly present in this merger.

- The Southeastern Pennsylvania health insurance market is clearly highly concentrated. IBC dominates the market with a market

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[17] *See* January 20, 2008 Testimony of Anita M. Smith at 1.

[18] "We wanted to have a statewide capability because of movement from local purchasing decisions [by customers] to decisions made more on a statewide and multistate basis.' ("Talking With Ken Melani," *Harrisburg Patriot News*, July 22, 2007, C08). "I personally believe it makes sense to have one statewide Blue Cross-Blue Shield organization. We'll work very hard to prove [our merger with IBC] works. Hopefully, it will further demonstrate to Capital and Northeastern that [merging the Blue Plans is] the right thing to do." ("Talking With Ken Melani," *Harrisburg Patriot News*, July 22, 2007, C08.)

[19] In testimony before the Pennsylvania Insurance Department Mr. Melani has suggested that Highmark's operations are not profitable in Central Pennsylvania. The fact those operations are less profitable than in Western Pennsylvania, where Highmark is dominant, suggests that the Central Pennsylvania market is far more competitive.

[20] 1984 GUIDELINES, at §4.112.

share of over 71 percent. There are only four other competitors in the market and the positions and market shares of those firms have been relatively stable for several years. This is clearly the type of oligopolistic market in which potential competition concerns are particularly important.

- The market has substantial entry barriers. As detailed in the expert testimony of Dr. Monica Noether, numerous firms have attempted to enter into the area and have failed—including, Health Plans of Pennsylvania; Horizon Healthcare of Pennsylvania; and Health Systems International.[21] What is striking about each of these failed entries is that each of these firms adopted different approaches to entry. Moreover, most national health insurers have been unable to establish even a minimal presence in the market. This is striking considering that Philadelphia and the Southeastern Pennsylvania area, is one of the most economically sound and fastest growing markets in the state. This strongly suggests that only another Blue Cross plan can be an effective entrant into the market.

- Finally, the history of Highmark's successful entry into Central Pennsylvania and the failed entry of several firms in Southeastern Pennsylvania demonstrates that Highmark is one of a very small set of firms capable of entering into the market.

- Highmark already has a network of healthcare providers in the market that provides Highmark a substantial advantage over other potential entrants. Highmark has an active statewide network of professional medical providers, including in the Southeast, because it has the statewide Blue Shield license. Traditionally, Blue Shield was the physician insurance and Blue Cross was the hospital insurance. Now, an insurer can offer full-line insurance with either a Blue Shield or Blue Cross license. Because Highmark has a statewide Blue Shield license, they can offer full-line health insurance in any part of the state. When Highmark entered Central Pennsylvania to compete with Capital Blue Cross, Highmark already had a network of physicians. Thus, Highmark only had to contract with hospitals to set up a hospital network in that region in order to independently offer full-line health insurance. Similarly, in order to offer full-line health insurance in the Southeastern Pennsylvania, Highmark needs only to contract with a relatively smaller number of hospitals for hospital services.

Let me close this discussion with an observation about the types of evidence in a potential competition case. The Clayton Act is an incipiency statute and as such it

[21] Testimony of Dr. Monica Noether, Competitive Analysis of the Proposed Consolidation between Highmark, Inc. and Independence Blue Cross (July 2, 2008).

deals with "probabilities and not certainties." In a potential competition case there can be "subjective evidence" of the parties' intent on entry and "objective evidence" focusing on more objective factors about the parties' incentives and abilities.[22]

Highmark has argued that subjective evidence is critical, suggesting that it is unlikely Highmark would enter the Southeastern Pennsylvania market since it lacks the intent to enter. But years of antitrust jurisprudence has been justifiably skeptical of such subjective evidence, especially in potential competition cases.[23] In this case, one should be particularly skeptical of such an assertion since it is contrary to Highmark's intent of becoming a statewide provider.

Objective evidence is typically given far greater weight. Thus, courts look for "objective evidence" such as the parties' expertise, financial wherewithal, previous attempts at entry, plans, and market conditions. Many of these facts are not public, but should be scrutinized through a thorough review by antitrust officials.[24] But Highmark's financial status, recent actions in entering into central Pennsylvania, entering into other markets, and unique ability to enter the market present strong objective evidence that it is a significant potential entrant.

The proposed efficiencies do not outweigh the competitive harm

Highmark and IBC contend that the consolidated company will save about $1.1 billion over the next six years. Of this total, they attribute $820 million to increased economies of scale, while $285 million stems from reducing the cost of pharmaceuticals. Moreover, the parties commit to direct $650 million of those savings to expand health insurance coverage for the uninsured in the Commonwealth.

At the outset we should recognize the importance of the commitment the parties have made to improve healthcare insurance coverage for the uninsured. As far as I know no other health insurers have made as substantial a commitment to the uninsured in any prior health insurance merger. With the chronic and increasing number of uninsured, the

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[22] Darren Bush and Salvatore Massa, "Rethinking the Potential Competition Doctrine, " 2004 Wis. L. Rev. 1035 (2004).

[23] *See United States v. Phillips Petroleum Co.*, 367 F. Supp. 1226, 1238 (C.D. Cal. 1973)("It will thus be in a company's self-interest to present subjective evidence of a lack of any intent to enter the market unilaterally and of a lack of any effect on the competitive behavior of firms in the market arising from the company's presence on the edge of the market."); *see also United States v. Falstaff Brewing Corp.*, 410 U.S. 526, 548 (1973)("where…strong objective evidence indicates that a firm is a potential entrant into a market, it is error for the trial judge to rely solely on the firm's subjective prediction of its own future conduct."); *Federal Trade Commission v. Procter & Gamble Co.*,386 U.S. 568 (1967).

[24] Claims that a firm is unlikely to enter a market but be evaluated carefully, including securing documents and testimony of company officials through compulsory process. A firm's claim that it has no intent to enter a market may be self-serving. We are concerned that level of scrutiny may not have occurred. It appears that the DOJ closed both of its investigations of the merger within 60 days after the Hart-Scott-Rodino filings were made, providing insufficient time for the agency to issue a Second Request for additional information.

parties should be commended for this commitment. Hopefully it will serve as a model for future mergers. Nevertheless, these efficiencies fall short.

The legal standard for the efficiencies defense is straightforward. Highmark must demonstrate that efficiencies are: (1) merger-specific; (2) cognizable and verifiable; and (3) sufficient in magnitude to reverse the anticompetitive effects of the merger.[25] Merger-specific means they must be "likely to be accomplished with the proposed merger and unlikely to be accomplished in absence of either the proposed merger or another means having comparable anticompetitive effect."[26] The claimed efficiencies cannot be efficiencies that could "be achieved by either company alone."[27] Moreover, because "information relating to the efficiencies is uniquely in the possession of the merging firms," the merging firms carry the burden of proof on efficiencies.[28] The alleged efficiencies cannot meet this standard.

Here there are significant reasons to be skeptical of the parties' efficiency arguments. First, as to the pharmaceutical costs, there is no reason to believe that combining Highmark and IBC will lead to savings of that magnitude. Pharmaceutical manufacturers give discounts based on the significance of a payor in a given geographic market. Simply combining the purchases of two geographic disperse payors will not necessarily lead to greater discounts. Moreover, even if it was the case that combining purchasing would lead to greater discounts such savings are not merger-specific. IBC, Highmark and even other insurers could achieve similar cost savings through a group purchasing arrangement.

The vast majority of the savings are from reductions in administrative costs. But the evidence from past health insurance mergers is that these savings rarely occur. As Professor Lawton Burns observed in testimony about this merger:

> [T]he recent historical experience with mergers of managed care plans and other types of enterprises does not reveal any long-term efficiencies.
>
> [E]ven in the presence of [efforts to achieve cost-savings] and defined post-integration strategies, scale economies and merger efficiencies are difficult to achieve. The econometric literature shows that scale economies in HMO health plans are reached at roughly 100,000 enrollees.... Moreover, the provision of health insurance (e.g., front-office and back-office functions) is a labor-intensive rather than capital-intensive industry. As a result, there are minimal economies to reap as scale increases.... Finally, there is little econometric evidence for economies of scope in these health plans – e.g., serving both the commercial and

[25] *1992 Merger Guidelines § 4; see also FTC v. H.J. Heinz,* 246 F.3d at 720- 21 (D.C. Cir. 2001)("a rigorous analysis" is required to ensure that the claims "represent more than mere speculation and promises"); FTC v. *Swedish Match,* 131 F. Supp.2d 151, 172 (D.D.C. 2000) (rejecting efficiencies claims that were "at best speculative"); *Staples,* 970 F. Supp. at 1089 (rejecting efficiencies claims that were not verifiable, credible or reliable).
[26] *1992 Merger Guidelines § 4.*
[27] *FTC v. Heinz,* 246 F.3d 708, 722 (D.C. Cir. 2001).
[28] *1992 Merger Guidelines § 4.*

> Medicare populations. Serving these different patient populations require different types of infrastructure. Hence, few efficiencies may be reaped from serving large and diverse client populations. Indeed, really large firms may suffer from diseconomies of scale.[29]

In fact, a recent analysis of mergers of Blue Cross plans over the past several years found little evidence that these mergers resulted in significant administrative savings.[30]

Conclusion

The Pennsylvania health insurance market is dominated by Highmark and IBC. Even though they currently are based in two different ends of the state, permitting their merger would permanently extinguish the opportunity for competition which has brought substantial benefits to Central Pennsylvania. Based on the dominant position of Highmark and IBC and the history of failed entry, it is highly unlikely any other firm could successfully enter these markets and improve competition. The right prescription for health insurance competition in Pennsylvania is to prohibit this merger.

[29] Testimony of Professor Lawton R. Burns regarding the Highmark/Independence Blue Cross Merger, before the Senate Judiciary Committee (April 9, 2007).
[30] Testimony of Diane Holder, President and CEO of the University of Pittsburgh Medical Center at 6-7.

American Antitrust Institute
The American Antitrust Institute ("AAI")is an independent Washington-based non-profit education, research, and advocacy organization. Their mission is to increase the role of competition, assure that competition works in the interests of consumers, and challenge abuses of concentrated economic power in the American and world economy.

U.S. Public Interest Research Group
U.S. Public Interest Research Group ("US PIRG") serves as the federation of non-profit, non-partisan state PIRGs, with over one million members nationwide. Achieving safe, affordable health care is a priority issue for the PIRGs.

Consumer Federation of America
The Consumer Federation of America ("CFA") is the nation's largest consumer-advocacy group, composed of over 280 state and local affiliates representing consumer, senior citizen, low income, labor, farm, public power and cooperative organizations, with more than 50 million individual members. CFA represents consumer interests before federal and state regulatory and legislative agencies and participates in court proceedings.

National Association for the Self-Employed
Then National Association for the Self-Employed ("NASE") represents hundreds of thousands of entrepreneurs and micro-businesses, and is the largest nonprofit, nonpartisan association of its kind in the United States. NASE supports the interests of the self-employed with benefits and advocacy initiatives aimed at leveling the playing field between these businesses and larger corporations.

United States Senate Committee on the Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights

Public Hearing

Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription?

July 31, 2008

Testimony by Joseph A. Frick

President and Chief Executive Officer

Independence Blue Cross

I also want to thank the Committee for the opportunity to speak with you today. As Ken mentioned, we have a proud tradition of serving our subscribers and our local communities. Our two organizations have had a long-standing and positive partnership, and we have a responsibility to promote the value and enhance the trust of the Blue brand, which serves more than one in three Americans.

So while coming together is a logical extension of our historical partnership, we believe that the business growth opportunities and anticipated efficiencies and savings will enable us to achieve several real and important goals. First and foremost, we are committed to help make health insurance more affordable. Affordability is the number one issue with our subscribers, and we have a responsibility to do better on this issue.

At the same time that our subscribers are demanding that we help control costs, they also want us to continue to invest in products and services to help improve quality and health care outcomes and to expand our efforts in health promotion and wellness programs.

Physicians, hospitals and other health care providers have been valued partners in our companies' mission of assuring access to high-quality networks of providers. We are committed to maintaining our well-established relationships with providers and enhancing incentive programs to help ensure the delivery of high-quality care.

We will continue to be a viable and successful leader in our communities. Our combined resources are expected to generate new business, which can help bring more jobs to Pennsylvania and stimulate additional business opportunities for Pennsylvania-based businesses.

Our final goal is to more effectively use technology to make it easier for our subscribers and providers to do business with us. We are committed to work tirelessly to achieve these goals.

To support these goals, we have identified tangible benefits that the proposed combination will achieve. By combining the two companies – and only by combining these companies – we will be able to generate more than $1 billion in additional economic benefits over six years. This is new money and goes beyond any commitments we have today.

These additional monies will be generated by savings from business efficiencies and growth opportunities that the companies could not produce individually. And unlike with consolidations of publicly held companies, where the savings flow to shareholders, every dollar of the economic benefits of this combination will go back to improving health care in Pennsylvania.

In addition to the $1 billion, we have also agreed to voluntarily extend the Community Health Reinvestment Agreement with the Commonwealth for three more years. That agreement is currently set to expire in 2010. This represents an additional, estimated $350 million that can be used to help more Pennsylvanians obtain health care coverage.

Let's now look at specific benefits for different industry stakeholders. For our subscribers, we pledge to freeze the administrative fees of their health insurance premiums for two years. This represents a direct savings to our subscribers of $295 million.

In addition to the administrative cost commitments, we also expect to save our subscribers another $285 million on prescription drug costs by capturing higher rebates and pharmacy discounts and lowering administrative costs – savings possible only with a larger subscriber base.

We expect that an estimated $100 million of the efficiencies generated by the consolidation will be used to fund expanded health care quality programs. These could include continuing and expanding each company's ePrescribing programs and encouraging implementation of standardized personal health records and electronic medical records. Greater use of these tools leads to higher quality care and fewer medication errors, which will result in greater savings for subscribers in the long run.

The new company also plans to combine and expand the best of the health promotion and wellness programs offered today by Highmark and IBC to help improve the health and well-being of our subscribers. Over time, a healthier workforce will be more productive at work and consume fewer health services. Moreover, we will offer our subscribers a wider array of products and services – integrating vision, dental and disability programs to their medical and pharmacy health plan choices.

We are proud of our long-standing relationships with physicians, hospitals and other providers. The value of our brand is based on the fact that we offer our subscribers broad, high-quality provider networks – and health care providers will remain important partners in the future. We believe the consolidation will benefit health care providers in a number of ways.

In the past few years, IBC and Highmark have pioneered a technology tool called NaviNet to help simplify administrative transactions with physician offices and hospitals. The consolidation will enable us to build upon this capability so that physician offices and hospitals can spend more time to improve patient outcomes, patient safety and the health and wellness of their patients, and worry less about administrative tasks.

We will be committed to provider payment levels that preserve our networks and help promote optimal quality of care. This is why we plan to expand pay-for-performance programs that provide incentives for health care providers to deliver increasingly high-quality care. We all recognize that payments based on volume of services are no longer sustainable in today's health care environment, and that incentives must be aligned to promote quality of care and the delivery of evidence-based care.

And here is one very important point. Not one dollar of the $1 billion in economic benefits will result from reductions in provider reimbursement.

Over the past few years, Highmark and IBC have developed close working relationships with hospitals and physicians which are focused on improving patient safety and reducing prescribing errors. The new company will seek to expand these partnerships to help raise the bar in the delivery of high-quality care.

Lastly, let me talk about how the consolidation will benefit our local communities, where our employees, our subscribers and their families live and work. IBC and Highmark have carried out our community mission in many ways, none more critical than offering coverage to individuals and families who the large, for-profit insurers will not insure. Our coming together will enable us to continue to subsidize programs for the uninsured, lower-income families and older adults. In addition, we will commit $300 million to new and existing programs for the uninsured, the underinsured and small business employees. The new company intends to work with key stakeholders and public officials to identify the most effective ways of using these monies.

Together, these commitments total $1 billion in new money, plus the additional $350 million to extend our commitment to the Community Health Reinvestment Agreement.

The new company will build upon our long-standing support for programs and services aimed at addressing community health needs. We believe there will be tremendous opportunity to expand our companies' current programs statewide, such as grieving centers for children and families, funding for medical and dental clinics for the uninsured, addressing childhood health issues and providing scholarships to increase the supply of nurses. Just last year, IBC and Highmark provided about $200 million in community contributions to expand access to health insurance and support a variety of community health and human services programs and services.

In conclusion, the consolidation is important for us to remain a viable, non-profit company that will strengthen our commitment to the community and economy of Pennsylvania. Do we expect to grow our business? Absolutely. And this business growth and the resulting revenue will be supported by additional jobs and investments in Pennsylvania.

No one company or organization, alone, can solve all the problems of the health care system. We believe, however, this consolidation offers a pathway to positive change in our health care system that Pennsylvanians are looking for.

Thank you.

United States Senate Committee on the Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights

Public Hearing

Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription?

July 31, 2008

Testimony by Barry C. Harris, Ph.D.

Chairman, Economists, Inc.

My name is Barry Harris. I am board chairman of Economists, Inc., here in Washington and am a former Deputy Assistant Attorney General in charge of economics at the Antitrust Division of the Department of Justice.

I submitted a report to the Pennsylvania Insurance Department in January of this year. In that report, I addressed whether the proposed consolidation will have the effect of substantially lessening competition in the sale of health insurance in Pennsylvania or will tend to create a monopoly in any health insurance market in Pennsylvania.

My overall conclusion is that the proposed transaction will not substantially lessen competition in any relevant health insurance market in Pennsylvania.

Let me now turn to the reasons for this conclusion. My primary focus today is the market for commercial health insurance which makes up the vast majority of the health insurance businesses for both Highmark and IBC. First, I will discuss what is meant by competition.

In a competitive analysis, two suppliers of a product or service are competitors when a set of customers considers them to be reasonable substitutes for each other. That is, if customers cannot choose between the products of the two firms, then the firms simply are not competitors and are not in the same market. For health insurance products, it is appropriate to focus separately on

individuals, small group purchasers and large group purchasers because these groups may not have the same choice of insurers to which they can turn. For example, individuals and small group customers do not normally have the choice of self insurance that is often selected by large group customers.

More generally, if two suppliers operate in the same geographic area but do not offer products that customers find to be reasonable substitutes for each other, then these suppliers are not competitors. Similarly, if the two suppliers offer products that are reasonable substitutes for each other, but these products are not available to buyers in the same geographic area, then these suppliers also are not competitors.

In order to address whether a particular transaction reduces competition, it is necessary to ask whether the transaction substantially reduces the choices available to customers. This is a fact-based inquiry that requires a careful review of the specific facts related to the specific transaction. To answer these questions, a competitive analysis typically considers relevant markets.

The word "market" can mean many things in conversation, but it has a very specific meaning in competition analysis. A relevant market for competition analysis identifies and includes the choices available to customers, and it accounts for both the competing products or services and the geographic areas in which they

are offered. At the end of the day, the concept of a market is quite simple. If the products are not substitutes, then they are not in the same product market.

Let me now turn to the specific facts of the proposed Highmark/IBC consolidation. I found that IBC and Highmark are not reasonable alternatives for one another. The simple reason is that IBC and Highmark do not sell commercial health insurance to the same customers in the same geographic markets, whether the focus is on sales to individuals, small groups, or large groups.

I found that the relevant geographic markets for commercial health insurance in Pennsylvania are distinctly local or regional and certainly are not statewide. Commercial health insurance customers purchase health insurance products that offer the services of physicians, hospitals and other medical providers close to where they or their employees work and live. The same conclusion about the local nature of health insurance markets was reached by the American Medical Association in its 2007 update of competition in health insurance. This is not simply an opinion, but reflects the actual facts about where customers in Pennsylvania can buy commercial health insurance products and from whom.

In considering these local markets, I first focused on IBC. IBC markets and sells commercial health insurance products to groups and individuals in only the five counties located in the southeastern region of Pennsylvania. Highmark does not market or sell commercial health insurance in these five

counties, though it does provide a variety of services to IBC through their Joint Operating Agreement and other joint venture agreements that have been place for many years.

For its part, Highmark markets and sells commercial health insurance products to groups and individuals only in the 29 counties located in the western region and the 21 counties in the central region of Pennsylvania. IBC is not licensed to use any Blue trademark in those areas of Pennsylvania and does not sell commercial health insurance to groups or individuals in the counties where Highmark offers its products. Consequently, Highmark and IBC are not competitors and are not in the same geographic markets.

The mere fact that Highmark and IBC both sell commercial health insurance products to customers in Pennsylvania does not make them competitors, since they operate in different geographic markets and since individuals and business owners in Pennsylvania cannot and do not choose between IBC and Highmark when buying health insurance.

Highmark and IBC, however, do compete against other commercial health insurers in their respective geographic markets. Competitors to IBC in the southeast region of Pennsylvania include Aetna, United Healthcare, CIGNA and HealthAmerica. Customers in southeastern Pennsylvania cannot turn to Highmark; they cannot turn to Capital Blue Cross; they cannot turn to UPMC; they cannot

turn to Geisinger; and they cannot turn to Northeastern Blue Cross. And moreover, they cannot access the rates Aetna and the other commercial insurers offer to consumers residing outside the southeastern region. For these reasons, the southeast region is an appropriate market for competition analysis.

With respect to western Pennsylvania, competitors to Highmark in western Pennsylvania include UPMC Health Plan, HealthAmerica, Aetna, and United Healthcare. Residents of western Pennsylvania cannot turn to IBC or Capital Blue Cross or Northeastern Blue Cross, nor can they access the rates offered to residents of other areas. Consequently, the western region of Pennsylvania is an appropriate market for competition analysis.

And finally, turning to the central region of Pennsylvania, competitors to Highmark include Capital Blue Cross, HealthAmerica, Aetna and the Geisinger Health Plan. Residents of central Pennsylvania cannot turn to IBC or Northeastern Blue Cross or UPMC, nor can they access the rates offered to residents of other regions of the Commonwealth. Consequently, the central region is an appropriate market for competition analysis.

These other competitors that I mentioned provide choices to consumers of commercial health insurance in each of these regions. These choices will not change as a result of the proposed transaction. That is, choices will not change as a result of the transaction in the southeastern region, the central region,

the western region or anywhere else. Consumers will have the same choices before and after the proposed transaction. This means there will be no elimination or lessening of competition as a result of the consolidation of Highmark and IBC.

This conclusion applies equally to individual purchasers, small group purchasers and large group purchasers. It also applies to so-called statewide purchasers. It is true that some purchasers of health insurance want coverage throughout the state or the nation for their employees. This, however, does not mean there is a statewide or nationwide market. There is a difference between where consumers physically consume or use a product and where they can actually turn to purchase that product. It is the second consideration that determines the geographic market definition. For example, a company headquartered in Harrisburg that wants health insurance for its employees located throughout Pennsylvania or the United States cannot turn to IBC to purchase this product.

The issue of potential competition has been raised in this matter, and specifically whether Highmark would enter the southeast Pennsylvania market if there were no Highmark/IBC consolidation. In the past I have dealt with the issue of potential competition under the federal antitrust laws, and I would like to comment on its relevance here. First, potential competition is an issue that only comes into competition analysis under very specific circumstances and thus is fairly unusual. Second, several conditions must all be present for the concept to

apply. The most important of these conditions is that if Highmark does not plan to enter the southeastern Pennsylvania region in the absence of the transaction, then there is no basis to apply the concept of potential competition.[1]

My overall conclusions may be summarized as follows. First, markets for commercial health insurance products are local and regional and are not statewide. Second, IBC and Highmark do not compete for the same buyers of commercial health insurance in any part of Pennsylvania and therefore are not in the same geographic markets. Third, the proposed transaction will not reduce or change the choices available to buyers of commercial health insurance anywhere in Pennsylvania.

My conclusions are entirely consistent with the decisions of the Department of Justice, which has twice reviewed and cleared the proposed consolidation through the HSR process. The second filing became necessary because HSR clearance is effective for one year, and the Pennsylvania Insurance Department process has extended beyond that initial one-year period. During one or both of these reviews, the DOJ investigated the horizontal competition and potential competition issues I have addressed, including an evaluation of both commercial and noncommercial health insurance products. The DOJ's repeated

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[1] The potential competition doctrine also does not come into play unless a market is suffering from a lack of competition already and unless the potential competitor is the most likely source of new competition absent the transaction at hand.

clearance of the transaction demonstrates that it concluded, as I have, that the consolidation would not eliminate meaningful competition or potential competition in any geographic market or for any Pennsylvania customers, including individuals, small groups or large groups.

STATEMENT OF SENATOR HERB KOHL

Good afternoon. Today we examine consolidation in the health insurance market, specifically a merger of the two largest health insurers in Pennsylvania, Highmark and Independence Blue Cross. We are holding this hearing at the specific request of my colleague for whom I have the highest regard, Senator Specter. As this merger most directly impacts Pennsylvania residents, I have asked him to preside over today's hearing.

After the merger, these two insurers' combined market share in Pennsylvania is estimated to be more than 70 percent. Allowing a single health insurer to gain such a high market share in Pennsylvania obviously raises significant competition concerns for the citizens of that commonwealth – especially since these two companies apparently agreed not to compete a decade ago. But it is also important that we consider competition in health insurance across the country. As health care costs continue to rise, consumers face ever increasing premiums. At the same time, we hear complaints from physicians and hospitals of declining reimbursement and "take it or leave it" contracts that negatively affect patient care. New competitors face high barriers to entry, so allowing high levels of concentration can have serious and lasting effects for many years to come.

And the statistics point to substantial evidence of rising consolidation in an already highly concentrated health insurance market. In 299 of the 313 metropolitan areas studied by the American Medical Association last year, health insurance was a highly concentrated industry under Justice Department guidelines. The number of health insurers nationwide have fallen by 20% since 2000. And this has clearly contributed to rising insurance rates. The AMA study found insurance rates were 12 percent lower in states with more competitive choices. The burden of ever rising insurance rates is borne particularly heavily by small businesses, who find it increasingly difficult to offer health insurance for their employees. And the problems of increasing concentration is compounded by the failure of the Justice Department to enforce the antitrust law in this industry. According to the 2007 AMA study, in the last 12 years, out of 400 health insurance mergers, the Justice Department challenged only two.

Vigorous competition in health insurance is essential to lowering health insurance premiums for consumers, and for businesses, and to assuring adequate payments to health care providers. We on the Antitrust Subcommittee will pay close attention to competition in health insurance markets in the months ahead. We will consider holding hearings on health insurance competition at the national level, and plan to ask the GAO to study the impact of consolidation on rising health insurance prices.

For all these reasons, today's hearing is a particularly relevant for our Subcommittee, and I thank Senator Specter for his work on this important issue. I now turn over the gavel to Senator Specter to preside at this hearing.

Testimony Regarding the Highmark BC/BS and Independence BC Consolidation

The Pennsylvania Insurance Department
Public Hearing: July 8, 2008
By: Diane Holder, President and CEO
UPMC Health Plan and Insurance Services Division

Good afternoon. My name is Diane Holder. I am an Executive Vice President of the University of Pittsburgh Medical Center and the President and CEO of the UPMC Health Plan. I appreciate the opportunity to come before you to provide testimony related to the potential consolidation of Highmark and Independence Blue Cross. For those of you who may be less familiar with the UPMC, we are an integrated delivery and financing system and the second largest non-governmental employer in Pennsylvania. Our health insurance companies provide health care financing services to over 1.2 million members through a variety of insurance and prepaid health plan programs. These programs include commercial insured and self funded arrangements, Medicare, Medicaid, Behavioral Health programs and workplace plans like short term disability, employee assistance and wellness programs. We pay more than $2 billion annually in health care claims and health care costs for our Pennsylvania customers.

Our health plans were created twelve years ago in response to the need for alternatives to the Blue Cross and commercial companies that existed. We have grown to serve more than 6,000 employers in Western Pennsylvania. We have developed a strong working relationship with the Department of Public Welfare, and are proud that we have been the fastest growing Medicaid plan in our HealthChoices zone for the past two years. In fact, nearly two out of every three newly eligible Medicaid recipients in our HealthChoices zone choose our plan, UPMC *for You*, over the competitive options. We also serve Medicaid members statewide through our behavioral health company, Community Care. Additionally, we have seen strong growth in our Medicare programs in part driven by our exceptionally high retention rates of over 95% (2008). We also have the only large Special Needs Plan for dually eligible Medicaid and Medicare members in our region that has experienced growth at all. Our two-year-old Children's Health Insurance Program exceeded 5,000 children in record time, and we are also pleased that our EAP and wellness programs have been well received by our large and mid-sized employers. We focus on clinical quality outcomes and have received recognition for our quality outcomes, innovation and ethics.

The landscape in Pennsylvania has been competitive, but we have succeeded in growing our companies across all lines of business within Western Pennsylvania and, in some cases, across the Commonwealth. We focus on bringing affordable options, innovative programs, high quality outcomes and an exceptional level of service to our customers.

Although commercial membership growth is challenging, we have had some success. However, our greatest growth in recent years has been across all of our government programs, where historical distribution channels are less relevant than in commercial products. A competitive insurance market benefits the public and drives innovation, cost containment and quality. We are very concerned that the proposed Highmark/IBC merger will reduce the competitive opportunities in the State across commercial and governmental business, resulting in fewer choices for consumers and ultimately, higher costs, less innovation and lower quality. Consequently, we oppose the merger.

What are the Key Reasons We are Opposed to the Merger?

There are three key reasons for our opposition. First, the newly created entity will create a dominant statewide company that will diminish competition from other health insurers;

Second, the transaction will harm consumers because diminished competition increases costs, reduces access and leads to less innovation and quality improvement;

Finally, an entity the size of the combined Highmark/IBC will have the ability to unduly influence health policy and regulation in the Commonwealth of Pennsylvania in ways that will not be in the best interests of Pennsylvania consumers.

We greatly appreciate that the role of the Pennsylvania Insurance Department is to protect consumers and ensure that those consumers have access to high quality, affordable health care. The Insurance Company Holding Act provides that the focus of the Department should be the impact of the proposed merger on the competitiveness of the health insurance market. At the heart of that discussion is the question: Do these companies operate on a regional basis or are they statewide competitors? Highmark and IBC both argue that they are regional plans and not statewide competitors. The fact is Pennsylvania is one of the few states with separate Blue Cross and Blue Shield licensees. Highmark controls the Blue Shield license for the entire state and can compete across the entire state. It utilizes its license in western Pennsylvania, in conjunction with its Blue Cross license, but it also competes in Northeast Pennsylvania in conjunction with Blue Cross of Northeast PA, and it competes in the center of the state directly against Capital Blue Cross. The fact that Highmark does not compete in the eastern portion of the state, in and around Philadelphia, is not a function of separate licensed geographic areas for Highmark and IBC, but rather, of a recently expired agreement between the plans **not to compete**. An agreement not to compete should not be the basis on which the Department defines the market.

How Unprecedented would this New Entity Be?

The size of the new entity that would be created would be unprecedented in any **one geographical market** in the United States. It takes a moderately competitive market, as Pennsylvania now stands, and creates a new dominant competitor with a statewide footprint. Highmark/IBC would account for approximately 75 percent of the statewide HMO enrollment and 64 percent of the PPO enrollment for commercially insured residents. Collectively, they would provide coverage to 7 out of 10 Pennsylvania commercially insured residents under age 65. Additionally, the combined entity will operate the largest Administrative Services Only provider for large employers in Pennsylvania, a platform it will use to solidify its dominant health insurance market position. The combined entity will be a mega insurer, the eighth largest in the nation. The other mega insurers operate in at least four states, most of them in 20 or more. In

contrast, almost all of the new entity's business will be **concentrated in one state**: Pennsylvania. It will hold more than $10 billion in assets (including nearly nine billion in cash and investments) and almost $7 billion in capital and surplus (based on December 31, 2007 numbers). Its 2007 Pennsylvania derived premium revenue of more than $12 billion will be almost seven times more than the next largest health insurer operating in the Commonwealth.

Let me now turn to public sector government business, which is of equal importance in understanding the problems inherent this potential merger. Currently, Medicare Advantage and Medicaid Managed Care markets are more competitive than commercial markets in Pennsylvania. Highmark and IBC separately have less than 50% of MA and even less in Medicaid. The consolidation will enable the new entity to become even more dominant in the Medicare market. For example, in the Lehigh Capital region post this merger, 80% of the Medicaid members will be covered through the new entity vs. only 40% covered by IBC and Highmark today. Similarly, it will be in a position to use its enormous surplus to potentially drive Medicaid competitors from the market. The new entity will be positioned to control market pricing over the long run, deciding when to bid aggressively and when to raise pricing significantly, as we have seen occur repeatedly over the years in the commercial group health business where pricing "bounces" significantly. This consolidation also positions the new entity to take advantage of any new Federal insurance changes that may to be on the horizon, which are procured and implemented at the State level. This could include group purchasing coalitions or individual coverage programs, with or without premium support from government.

In short, the proposed merger is one of the largest of its kind in U.S. history, and will convert a competitive market to one controlled by a monolithic competitor overnight. Highmark/IBC will control all markets in which it competes: Commercial (individual as well as small, mid and large group); Medicaid; Medicare; stop loss; dental; vision; and ASO business.

Will this Merger Improve Affordability, Access and Quality?

Our second key reason for opposing the proposed merger is the concern that it will harm consumers and not improve affordability, access or quality.

Value to the consumer comes in the form of more affordable health care. Affordability requires lower costs. Health care costs have two parts: what is spent on medical care and what is spent on administrative expenses. When we evaluate the reasons for the health care cost increases in the United States, the most significant cost drivers for the past two decades have been the **increase in the prevalence of chronic conditions and the increase in what is called the "treated prevalence" of disease**. That is, more people have disease, and more people who have disease are being treated for those conditions, including treatment with new technologies. Administrative costs, although very important to control, do not appear to have contributed to the **trend** in cost increases. If health care is going to become more affordable, there has to be a way to deal with the cost factors that are actually driving trends. Highmark and IBC have yet to show that the proposed merger will enable them to control medical spend more effectively together than they can independently. Are they planning to adequately reimburse hospitals and physicians? Pennsylvania hospitals are already on average financially fragile, and Pennsylvania is already losing physicians to markets where reimbursement is more attractive. New and innovative ways are needed to prevent and treat chronic disease. There is no reason to think larger insurers are more effective in producing higher quality outcomes. In fact, most of the insurers nationwide that score the highest in quality outcomes for their members are **smaller often regional** plans, which have the ability and the primary mission to focus on local care strategies with their members and the local physician and hospital communities.

The second way to reduce costs is to lower the administrative portion of the expense. Highmark and IBC contend they will do this as part of the value of the consolidation. There is no evidence, however, that mergers of health insurance companies result in lower administrative costs. My written testimony includes a chart showing

administrative costs before and after mergers of Blues plans. It shows that post merger, there is **no** reduction in administrative costs as a percentage of premiums.*** (The same is true for non-Blues plan mergers.) We would ask for specific substantive evidence that health insurance mergers like this one will result in administrative savings that benefit premium pricing and consumer affordability.*****

Table 2-3

Administrative Costs as a Percent of Premium Revenues[1]

Selected Blue Cross and Blue Shield Plans

2007

Plan	Administrative Cost – Year Prior to Merger	Administrative Cost – 2007
CareFirst BCBS (Consolidated in 1997)	10.8%	11.4%
CareFirst BCBS of Maryland	10.2%	9.9%
CareFirst (DC, VA)	11.4%	12.7%
Wellmark BCBS (Consolidated in 1995)	9.3%	9.3%
Wellmark Iowa	9.6%	9.8%
Wellmark South Dakota	6.9%	6.7%
Regence BCBS (Consolidated in 2000)	9.1%	9.8%
Idaho/Washington	12.9%	14.8%
Oregon	9.1%	8.6%
Utah	10.4%	10.5%

Is a Merger Required to Reduce Administrative Costs?

The answer is no. It is possible to be a smaller plan and have lower administrative costs. The UPMC health plans have consistently run at or below 8% administrative

[1] NAIC Annual Financial Summaries compiled by NCI

costs and we have not needed the alleged scale economies to achieve this relatively low administrative cost structure. What we have needed is efficient methods, and a competitive need to keep costs low to grow our business. Lower overhead is one of the reasons we have been successful. We would ask the Department to evaluate what the track record has been for other mergers, including the merger between Blue Cross and Blue Shield to create Highmark in l996. Did the merger create administrative efficiencies that led to lower administrative expense ratios? It does not appear to us that it did. A review of Blues mergers in other parts of the U.S. suggests the same result. We find that there is little reason to believe that either scale or scope economies will result in savings.[1]

Are Premiums Higher in States with More Concentrated Markets?

Are premiums higher in states with more concentrated markets? The answer is yes. In general, our evaluation shows that in states where there is more competition among health insurers, consumers win. Where companies compete, they develop new and innovative ways of delivering their products or services and seek out the highest level of efficiency for that delivery. The result is more affordable prices for customers. Health insurance is no different. An examination of data from 31 states generated by the Department of Justice and the Association of Health Insurance Plans shows that the average cost of health insurance premiums in states with higher-than-average levels of competition is 12% lower than premiums in states with lower-than-average competition.

	States with Better than Average Competitive Profiles	States with Worse than Average Competitive Profiles
Average HHI (competitiveness measure used by DOJ)	*2,672*	*4,060*
Average Aggregate Annual Group and Individual Premium	*$5,068*	*$5,676 (12.0% higher)*

States with Better than Average Competitive Profiles: Arizona, Delaware, Idaho, Illinois, Nebraska, Nevada, New Jersey, New Mexico, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Virginia, Washington
States with Worse than Average Competitive Profiles: Connecticut, Georgia, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Missouri, New Hampshire, North Carolina, South Carolina, Wyoming

Sources: AMA, Department of Justice, Association of Health Insurance Plans

Will the Merger Improve Access to Quality Health Care?

To answer that question, the Department must consider the impact of the merger on health care providers -- physicians and hospitals. If the merger reduces access to quality health care, consumers are hurt. After their consolidation, Highmark/IBC will have even more negotiating power, enabling it to reduce the prices it pays to providers. If health care providers are forced to leave the state or close operations in areas of the state that currently have marginal access, or have no resources to invest in aging plants or improved technology, consumers suffer. In fact, data show that health care providers are on more tenuous financial ground in those states where there are dominant health insurance companies. The health care providers -- doctors and hospitals -- have older facilities, less money available for upgrading care and services, and limited opportunity to save for future needs. Pennsylvania hospitals on average already perform below national averages across key financial indicators, as reflected in the chart included in

my written testimony. The system is fragile, and in Pennsylvania, we have the additional responsibility of caring for one of the nation's oldest populations.

Key Hospital Financial Indicators -- Pennsylvania

	2001	2002	2003	2004	2005
Operating Margin (%)					
U.S.	0.95	1.56	1.70	2.17	2.89
S&P AA Rated	1.67	1.53	3.10	5.62	4.60
Pennsylvania	0.12	-0.13	0.09	1.58	2.79
Current Ratio (Median)					
U.S.	1.99	2.00	2.05	2.04	2.08
S&P AA Rated	2.04	2.05	2.22	2.15	2.06
Pennsylvania	1.63	1.64	1.61	1.42	1.57
Debt Service Coverage					
U.S.	3.14	3.01	3.17	3.43	3.90
S&P AA Rated	3.85	3.78	3.92	5.21	7.06
Pennsylvania	2.72	2.26	2.14	3.32	3.07
Average Age of Plant (Years)					
U.S.	9.67	9.76	9.83	9.83	9.84
S&P AA Rated	9.28	9.24	10.01	10.53	10.23
Pennsylvania	11.10	11..41	11.93	11.24	11.21

Source: Ingenix, Almanac of Hospital Financial Indicators, 2007

The answer to the second question -- will the proposed merger benefit consumers? -- is no. It will not improve affordability of health care, access to health care or quality of care. In fact, the merger will be harmful to all three.

Will A Mega Plan Have Too Much Health Plan Influence?

The third reason we oppose the merger relates to the role an entity this size has in influencing health policy and health care regulatory issues. Questions such as: What should be the size of allowable reserves? How can reserves be used? What is considered a community benefit? What services such as pharmacy or mental health should be carved in or carved out of capitated benefits? What should pay-for-performance plans look like? How should risk pools be established? What is the role

of consumer oversight? Legislative oversight? As well as a myriad of other questions that are the purview of not only the Insurance Department, but also the Department of Health; Department of Public Welfare; and the Office of Health Care Reform and our legislators, among others.

The proposed merger will concentrate even greater influence in policymaking matters into the hands of one organization. It may be difficult for officials to manage an organization that represents eight million citizens on complex, industry-specific issues that are often shades of grey rather than black and white. In other states, when market share has been highly concentrated, the influence of the dominant entity appears to grow. For example, there is significant documentation of concerns among citizens in Michigan related to consolidation and the resulting influence there. We are able to provide the presentation from the Coalition for Access and Affordability that was given to the Michigan legislature in April, 2008 for your further review.

On a Final Note

The merged companies would reportedly return one billion dollars to the Commonwealth in the form of community investment. The size of the investment being offered by the two companies in return for approval of the merger seems woefully inadequate for the premium revenue they will derive from the Pennsylvania insurance market, which we estimate to be approximately $500 billion over a ten-year period. A similar transaction among publicly traded companies would require an investment of tens of billions of dollars.

We question the future agenda of the merged entity given Highmark's and IBC's conduct over the past ten years, including: (1) the merger of Blue Cross and Blue Shield to create Highmark; (2) the failed attempt by Highmark to merge with Capital Blue Cross, (3) Highmark's acquisition of a sizable percentage of Northeast Blue Cross; (4) the parties' agreement not to compete in Eastern Pennsylvania; and (5) filing for

consolidation when the ten-year non-compete expires. All of this conduct paves the way for these two companies to create a single dominant state-wide insurer for all government and commercial products. We are concerned that if this consolidation occurs, the combination is more likely to convert to a publicly traded company in the future. The market value of what will be created is something that we believe the Department should appraise. A billion dollars seems an unusually low contribution for the opportunity to control virtually all market segments in such a large state.

Summary

In summary, I would like to thank you for the opportunity to provide this testimony. We believe that Pennsylvania has never faced a more important health policy decision. Whether to allow the creation of a behemoth health insurer within the boundaries of Pennsylvania will have a more profound and lasting impact on health outcomes for the citizens of Pennsylvania than any other decision that will be made regarding health policy for the foreseeable future. We see the obvious benefit to Highmark and IBC. We do not see a public benefit for consumers or a benefit of this transaction for other health care stakeholders.

Douglas Wholey a,*, Roger Feldman b, Jon B. Christianson b
a Department of Social and Decision Sciences, Carnegie-Mellon University, Pittsburgh, PA 15213
b . Institute for Health Services Research, School of Public Health, University of Minnesota, Minneapolis, MN 55455,
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Ruth S. Given *
California Medical Association, 221 Main Street, PO Box 7690, San Francisco, CA 94120-7690, USA
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Testimony of
Michael B. Laign
President/CEO, Holy Redeemer Health System
Before
The United States Senate Committee on Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights
July 31, 2008
Consolidation in the Pennsylvania Insurance Industry:
Right Prescription?

Chairman Kohl, Senator Specter and Members of the Subcommittee,

My name is Michael Laign. I am President and CEO of Holy Redeemer Health System — a non-profit organization which provides a wide range of healthcare and health-related services, including an acute care hospital, home health and hospice services in Pennsylvania and New Jersey, two skilled nursing facilities, assisted living, a retirement community, low-income housing, an active living community, and a transitional housing program for homeless women and children.

While not an expert on federal antitrust issues, I appreciate the opportunity to share our views with the Subcommittee on the proposed merger and consolidation of IBC and Highmark, particularly as IBC coverage/programs today represent approximately 24 percent of our existing revenue.

At the outset, I want to commend Senator Specter for his role in holding this public hearing as well as the hearing in Philadelphia in April of 2007. Given the significance of this issue, we appreciate Senator Specter's commitment to ensuring that the consideration of this proposed merger is as transparent as possible. In addition to their roles as major health insurers, Highmark and IBC are important parts of the business and civic fabric of their respective communities. All of us in the Commonwealth have a stake in the outcome of this process.

While I share some of the fears and concerns expressed by some of the other witnesses here today, on balance I see this merger as an opportunity to address needed change to the health care delivery and financing system in Pennsylvania.

To achieve positive change, however, I believe there are a number of important safeguards that must be implemented as a part of this merger. I will touch on these safeguards in a moment.

Why does this merger deserve serious consideration? I think we have to start from the premise that a strong, financially viable Blue Cross plan is in the interest of all consumers, businesses and providers in the Commonwealth. I think economies of scale and administrative efficiencies that can be achieved by this merger that are in the public interest.

Further, a Blues plan whose core business and interests are focused on Pennsylvania is in our collective long term interest. Given the consolidation trends nationally, if these two plans are not permitted to merge, I think it is only a matter of time before we will be participating in hearings in the Commonwealth about proposals for one or both plans to merge with or be acquired by an out of state entity. Holy Redeemer Health System would rather deal with a plan and a plan leadership with a vested interest in making Pennsylvania a better place to live and work.

I know arguments have been made on both sides of the issue about the competition or lack of competition between Highmark and IBC in Southeastern Pennsylvania and other parts of the state. The two plans point to the fact they don't currently compete as an indication that the merger won't affect the competitive state of the insurance market in our state. Whereas others suggest, that without the 1996 non-compete agreement, the two plans could compete today and that would be good for Pennsylvania consumers, business and providers.

In a sense both arguments are "right", but both miss the underlying long term challenge we face in making our health care system work better for all stakeholders. Yes, as a practical matter it is hard to see how IBC could get much stronger in Southeastern Pennsylvania . . . it has a dominant position that the merger will only marginally affect.

Some would argue that the market competition between Highmark and Capital Blue Cross was good for some businesses as well as some providers in the central part of the state, and therefore competition between Highmark and IBC would be good too.

But in my view both are short term arguments. From my perspective, our health care system has and will continue to suffer from an abundance of short term thinking, everyone, including government, is out to cut the best deal for themselves at the expense of creating an affordable, sustainable system that serves all our interests. We must all think of the long term costs to our communities of the considerable resources devoted to marketing, market share underwriting, duplicative administrative structures and, yes, possibly higher than necessary provider payments that would ensue for a period of time if these two plans were forced to compete head to head across our state.

I don't think we can afford the cost. I think we all recognize both in Pennsylvania and across the nation that the rate of increase in health insurance costs is not sustainable over the long run. Employers, consumers, state and the federal government are all struggling to maintain coverage not to mention the continuing growth of under and uninsured citizens.

In short, for us in Pennsylvania I think the merger between Highmark and IBC represents an opportunity to begin to rationalize and transform the health care system in the Commonwealth for the future. This is a once in a generation opportunity to help reform and shape the health care system through an health insurance enterprise that by all estimates would be responsible for over 50 percent of the health care lives and revenues in our state.

The merger done properly, with the right leadership, appropriate safeguards and appropriate, sustained government oversight, could help to:

1. Reduce the staggering administrative costs associated with our current health care system,
2. Improve quality by reducing regional variations in care and enhancing adoption of evidenced based standards of care,
3. Achieve greater uniformity in our patient safety and process improvement efforts,
4. Improve access to coverage,
5. Enhance the affordability of coverage
6. Create a more transparent system

If coordinated with complementary and consistent government health program policies, it should be possible to help drive many needed reforms of Pennsylvania's health care system. In making this case, I fully understand how difficult it will be to achieve these kinds of objectives. But not seizing this opportunity will result in business as usual.

We can't afford a business as usual approach. The current health care system is not sustainable for consumers, business or providers.

In Southeast PA, we have seen some glimpses of what the future could be. For the past several years, IBC has engaged the provider community in a series of partnerships. For example, IBC and an organization I chair, the Health Care Improvement Foundation, led the formation of the Partnership for Patient Care to coordinate patient safety and clinical process improvement efforts. Its focus is to accelerate the effective adoption of evidence-based clinical practices by pooling the resources, knowledge, and efforts of healthcare providers in our region. Every acute care hospital in the Delaware Valley has participated in the Partnership, and it has now been expanded to long term care providers and other stakeholders. Under this partnership we have tackled medication safety, health care acquired infections and a series of other issues ranging from patient falls to MRSA. Examples of the benefits include:

- Over 20 percent improvement in adoption of glucose control and antibiotic administration practices to prevent surgical site infections
- Reduced DVT (Deep Vein Thrombosis) complications through 20 percent gains in compliance with risk assessment and prevention protocols
- Leadership of the Fight MRSA! Alliance, taking action to address MRSA as a community-wide issue

This year we have undertaken projects involving to eliminate wrong-site surgery, prevent pressure ulcers across all types of care settings. IBC's substantive and financial contribution to these efforts has been a key part of our success.

On another level, my system, IBC and CARDONE INDUSTRIES (auto parts manufacturer) have collaborated to create a virtual partnership for the provision of high quality, cost-effective health care, wellness screenings, and illness prevention and education services for CARDONE employees and their families.

Through this partnership, which supports care coordination and care management, CARDONE INDUSTRIES is ensured healthier, more productive employees while the company benefits from reduction in health care-related expenses such as high cost drugs, inappropriate and over-utilization of services, as well as inconsistent access and other service issues.

As I indicated previously, any merger of Highmark and IBC must include important safeguards or conditions built into the approval process. I believe it will be necessary for state government to create a new oversight framework to ensure balanced mix of regulatory oversight and market forces which provide financial incentives that reward both payor and provider conduct that serves the interests of subscribers, patients and the overall public interest.

While I don't presume to have all of the answers, I would like to briefly summarize a few specific examples of the types of safeguards and conditions that I recently presented in testimony to the Pennsylvania Insurance Commissioner.

First, both Highmark and IBC have stated that the merger will result in a $1 billion dollars of savings by "providing scale, generating operational efficiencies and eliminating unnecessary redundancies." Much of this refers to new IT systems for claims processing and other administrative efficiencies.

We believe the department should require that these administrative efficiencies be clearly articulated and include an objective of moving towards all electronic claims submission, instant claims adjudication for the majority of claims and a reinstatement of Periodic Interim Payments (PIP) until those objectives are met and the new administrative systems are functioning properly. By implementing PIP, providers won't be penalized by claims processing foul ups and the new merged entity will have a financial incentive to get their systems operating, efficiently and effectively. Further, there should be a mechanism to help providers and the new company develop consensus on administrative standards, systems and technologies that could become the accepted standard for health related administrative transactions in Pennsylvania.

Second, I believe some of these savings should be devoted to enhancing access to primary care. In general, the payments to primary care providers are not enough to remain viable economically. According to a study of physician payments in our region, it appears that most commercial insurers' physician payments are based on some percentage above Medicare whereas Blue Cross payments were at times below Medicare. This is a market imbalance that needs to be addressed. It is in the interest of all concerned to make sure there is adequate access to primary care services.

Third, we need a more transparent system. At a minimum, there should be a periodic independent audit of the provider payment practices of all coverage plans under the

new merged Blue Company to assure that payments for services to all providers are adequate to sustain a quality health care delivery system for all Pennsylvanians.

Fourth, in recognition of the highly concentrated market conditions in Pennsylvania and the market power the merged Blue company would have, several safeguards new to be put into place.

A. Provider Payment Appeals Process: for individual and small groups of practitioners and other independent providers a mechanism should be created to help resolve contractual disputes related to payment terms and conditions.

B. Arbitrary Anti-competitive Practices should be barred. If the merger is approved, the new company should not be allowed to impose "most favored nation clauses" or other restrictions such as prohibitions on provider plans/risk bearing entities as a condition of entering into a Blue Cross contract.

Lastly, one of the key concerns is the accumulated surplus of both IBC and Highmark. If approved, the new merged entity should be required to work with state government and other stakeholders to design an actuarially sound catastrophic coverage plan that could cover all Pennsylvanians and that all residents would contribute to. While we don't have time to go into all the details of this proposal, the catastrophic coverage plan would have a high threshold and spread the costs over all residents, and therefore it would be relatively inexpensive. It would re-create the broadest possible risk pool for the relatively small number of catastrophic cases, reduce insurance costs for business, and protect every resident of Pennsylvania, both insured and uninsured, from what they fear the most . . . catastrophic costs of a major illness.

In effect the new merged company should play a "public utility role" for purposes of providing universal catastrophic coverage for all Pennsylvanians. By creating a universal mechanism to cover catastrophic illnesses, it should help stabilize private sector coverage as well as make it easier to fashion affordable market based solutions for routine medical expenses whether under the Governor's Cover All Pennsylvanians or other approaches. In short, catastrophic coverage is not a replacement for, but rather a step towards achieving our shared long term goal of comprehensive health insurance coverage for all residents of the Commonwealth.

Mr. Chairman, as I indicated previously, while Change is always Uncomfortable, I view this merger as an opportunity to help shape a new and better health care system for Pennsylvania. Again thank you for the opportunity to share our views. I would be happy to answer any questions you may have.

(MBL/dt: 7-30-08)

THE INSURANCE FEDERATION OF PENNSYLVANIA, INC.

Public Testimony

Prepared for

The Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights

ON

Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription?

July 31, 2008

The Insurance Federation of Pennsylvania, Inc.
1600 Market Street, Suite 1520
Philadelphia, PA 19103
215-665-0500

THANK YOU FOR THE OPPORTUNITY TO BE HERE. I AM SAM MARSHALL, PRESIDENT OF THE INSURANCE FEDERATION OF PENNSYLVANIA. WE'RE A TRADE ASSOCIATION REPRESENTING COMMERCIAL INSURERS IN ALL LINES OF INSURANCE IN PENNSYLVANIA. OUR MEMBERS INCLUDE MANY OF THE LARGE NATIONAL HEALTH INSURERS AND SOME OF THE FEW REMAINING SMALL LOCAL HEALTH INSURERS. WE REPRESENT FAMILIAR NAMES IN HEALTH INSURANCE - AETNA, UNITED, HEALTH AMERICA AND CIGNA TO NAME A FEW - BUT NONE WITH SIGNIFICANT MARKET SHARES WHEN COMPARED WITH ANY OF THE FOUR REGIONAL BLUES PLANS WITH WHICH WE TRY TO COMPETE.

ATTACHED TO MY TESTIMONY ARE THE COMMENTS WE SUBMITTED TO THE PENNSYLVANIA INSURANCE DEPARTMENT AND THE PENNSYLVANIA SENATE AND HOUSE INSURANCE COMMITTEES AS PART OF THEIR REVIEW OF THE PROPOSED CONSOLIDATION OF HIGHMARK AND IBC. I'LL SUMMARIZE: THIS CONSOLIDATION WILL LESSEN COMPETITION, BOTH POTENTIAL AND ACTUAL, AND WITHOUT ANY OFFSETTING UNIQUE BENEFITS OR EFFICIENCIES - ABSENT THE CONDITIONS WE RECOMMENDED. THOSE CONDITIONS ARE MEANT TO ENSURE THAT COMPETITION SURVIVES, AND THAT THERE IS MEANINGFUL ONGOING REGULATION OF THE CONSOLIDATED ENTITY TO ENSURE THAT THE PURPORTED SAVINGS ARE REALIZED AND GO TO THE PENNSYLVANIANS WHO PRODUCE THEM.

MAKE NO MISTAKE - THIS PROPOSED CONSOLIDATION WILL IMPACT COMPETITION. FIRST, IT ENDS THE POTENTIAL FOR HIGHMARK AND IBC COMPETING WITH EACH OTHER. THEIR CURRENT MANAGEMENTS MAY NOT

PLAN TO COMPETE, BUT THAT'S SUBJECT TO CHANGE. IN PENNSYLVANIA, WE'VE HAD SOME EXPERIENCE WITH BLUE-ON-BLUE COMPETITION BETWEEN HIGHMARK AND CAPITAL BLUE CROSS IN THE CENTRAL PART OF THE STATE - AND THE COMPANIES, AND CONSUMERS, REPORT IT HAS BEEN A GOOD THING.

SECOND, THE CONSOLIDATION WILL MAKE IT MORE DIFFICULT FOR OTHER INSURERS TO COMPETE. THERE'S BEEN A LOT OF DISCUSSION AND DOCUMENTATION OF THIS IN THE DEPARTMENT'S ONGOING REVIEW - BUT THE SIMPLEST EVIDENCE IS THAT HIGHMARK AND IBC HAVE BOTH SAID THEIR CONSOLIDATION WILL MAKE THEM EVEN MORE "COMPETITIVE". GIVEN THAT THEY ALREADY ENJOY VERTIABLE MONOPOLY STATUS IN THEIR OWN REGIONS, THAT'S ONLY GOING TO ENABLE THEM TO CRUSH OR DISCOURAGE ANY COMPETITIVE FORCES. THIS IS NOT BECAUSE THEY'VE BUILT A BETTER MOUSE TRAP, BUT BECAUSE THEY WILL EMERGE AS THE ONLY REAL GAME IN TOWN, ESPECIALLY IN NEGOTIATING WITH PROVIDERS, THE BIGGEST KEY TO BEING COMPETITIVE IN HEALTH INSURANCE.

I'M A FIRM BELIEVER THAT COMPETITION IS THE HALLMARK OF ANY VIABLE INSURANCE MARKET, WHERE CONSUMERS HAVE CHOICES AND WHERE INSURERS FACE THE OPPORTUNITIES AND PENALTIES THAT COME FROM EITHER ANSWERING OR FAILING TO ANSWER CONSUMER DEMANDS.

I'VE COME TO THAT BELIEF THROUGH HARD EXPERIENCE OVER THE PAST TWENTY-PLUS YEARS IN PENNSYLVANIA. VERITABLY EVERY LINE OF

COVERAGE HAS, AT SOME POINT, FACED THE CRISIS WE SEE IN HEALTH INSURANCE NOW - CONSUMERS NOT GETTING THE COVERAGE THEY WANT AT A PRICE THEY CAN AFFORD.

THE ONLY ANSWER THAT HAS WORKED HAS BEEN TO FOSTER COMPETITION. THE MOST PROMINENT EXAMPLE, ESPECIALLY FOR THOSE FROM PHILADELPHIA, IS OUR AUTO MARKET. BACK IN THE 1980s, WE FACED A LIMITED AND EXPENSIVE MARKET - NOT MANY INSURERS, AND CONSUMERS COULDN'T AFFORD THEIR PRICES. A NUMBER OF REFORMS WERE TRIED, BUT THE ONLY ONE THAT WORKED WAS A LAW IN 1990 THAT ENCOURAGED AND REWARDED NEW CARRIERS, NEW IDEAS AND MORE COMPETITION. THE RESULT OVER THE PAST 18 YEARS HAS BEEN FLAT RATES AND BROAD AVAILABILITY FOR ALL DRIVERS.

WE'VE SEEN THAT WORK IN OTHER LINES, TOO, WITH WORKERS COMPENSATION PROBABLY THE SECOND MOST PROMINENT EXAMPLE: IT WAS A BAD MARKET, VARIOUS REFORMS WERE TRIED, BUT THE ONLY ONE THAT WORKED WAS A LAW PASSED IN 1993 THAT BROUGHT IN NEW CARRIERS, NEW IDEAS AND MORE COMPETITION.

IT IS NO COINCIDENCE THAT OVER THE PAST TWENTY YEARS, THE TWO TOUGHEST LINES OF INSURANCE HAVE ALSO BEEN THE TWO MOST CONCENTRATED ONES - MEDICAL MALPRACTICE AND HEALTH INSURANCE. WE'RE SEEING SOME IMPROVEMENT IN THE MALPRACTICE AREA BECAUSE OF SOME RECENT REFORMS THAT HAVE ENCOURAGED MORE COMPETITION.

BUT WE HAVEN'T SEEN MUCH IN THE WAY OF REFORMS THAT HAVE ENCOURAGED COMPETITION IN HEALTH INSURANCE, AND I THINK THAT'S ONE OF THE MAIN REASONS WE HAVEN'T SEEN ANYWHERE NEAR THE PROGRESS CONSUMERS NEED. SOME OF THE HEALTH INSURANCE REFORMS THAT HAVE HELPED - THE GROWTH OF MANAGED CARE, WHICH MAY HAVE BEEN POORLY NAMED BUT PRODUCED SOME TANGIBLE SAVINGS; AND THE CONSUMER-DRIVEN ALTERNATIVES LIKE HEALTH SAVINGS ACCOUNTS - BOTH GERMINATED FROM SMALL INSURERS TRYING TO CREATE A NEW PRODUCT AND WAY TO GET INTO THE MARKET.

COMPETITION ALONE ISN'T THE ANSWER TO OUR COMMONWEALTH'S HEALTH INSURANCE PROBLEMS. BUT ANY OBJECTIVE ANALYSIS OF INSURANCE MARKETS HAS TO CONCLUDE THAT THE RIGHT PRESCRIPTION HAS TO INCLUDE A STRONGLY COMPETITIVE HEALTH INSURANCE MARKET - THAT'S THE BEST SOURCE OF INNOVATION, CUSTOMER RESPONSIVENESS AND TRUE EFFICIENCY. IT HAS PROVEN OVER THE YEARS TO WORK IN ALL OTHER LINES OF INSURANCE, AND IT NEEDS TO BE PART OF THE SOLUTION IN HEALTH CARE.

THAT DOESN'T MEAN CONSOLIDATIONS, EVEN OF THIS MAGNITUDE, ARE INHERENTLY FLAWED OR FATAL TO THE PROSPECT OF COMPETITION. IT DOES MEAN THAT CONSOLIDATIONS, ESPECIALLY OF THIS MANGITUDE, HAVE TO BE SCRUTINIZED AND ONLY APPROVED IF THEY COME WITH CONDITIONS THAT ENSURE THE CHANCE FOR OTHER CARRIERS TO THRIVE AND NEW IDEAS

TO EMERGE. THAT'S WHAT WE'VE RECOMMENDED TO THE INSURANCE DEPARTMENT. WE HOPE THAT'S THE OUTCOME.

ONE ADDED POINT IN CLOSING: THERE WAS AN OP-ED PIECE IN SUNDAY'S NEW YORK TIMES BY WILLIAM POOLE OF THE CATO INSTITUTE ON FANNIE MAE AND FREDDIE MAC, WHERE HE NOTED THE DANGER IN ALLOWING A CRUCIAL MARKET TO HAVE ONLY TWO OPERATORS, POINTING OUT THAT "MARKETS WORK BEST WHEN NUMEROUS FIRMS COMPETE AGAINST EACH OTHER". THAT'S WORTH REMEMBERING HERE: ANY MARKET THAT BECOMES A PRIVATE MONOPOLY IS IN DANGER OF BECOMING A HOSTAGE TO THAT MONOPOLY, NO MATTER HOW EXTENSIVE OR WELL-INTENTIONED THE REGULATORY OVERSIGHT. IT'S NOT JUST THAT COMPETITION GETS STIFLED, AND WITH IT THE PRESSURE TO DO BETTER. IT'S THAT CONSUMERS CAN BE HARMED BY THE ABSENCE OF THE CHECKS, BALANCES AND SAFETY VALVES THAT COME FROM A COMPETITIVE MARKET.

AGAIN, THANK YOU FOR THE CHANCE TO BE HERE. I'M HAPPY TO ANSWER ANY QUESTIONS.

The Insurance Federation of Pennsylvania, Inc.

1600 Market Street
Suite 1520
Philadelphia, PA 17101
Tel: (215) 665-0500 Fax: (215) 665-0540
E-mail: mailbox@ifpenn.org

Samuel R. Marshall
President & CEO

July 9, 2008

Robert Brackbill, Chief
Company Licensing Division
Pennsylvania Insurance Department
1345 Strawberry Square
Harrisburg, PA 17120

Re: The proposed consolidation of Highmark and IBC

Dear Mr. Brackbill:

We offer the following comments on behalf of the members of the Insurance Federation of Pennsylvania. These are preliminary comments, and we reserve the right to expand on them throughout the public comment period, both with the Department and with the Senate and House Insurance Committees and the Attorney General.

By way of introduction, the Federation is a non-profit trade association representing all lines of insurers doing business in this Commonwealth. Our members include a number of health insurers, although not the Blues. While many of our health insurer members are familiar names, none approach the market size of Highmark and IBC in their services areas and in Pennsylvania. Further, our members compete with each other. As an association, the Federation is committed to regulatory and legislative policies that foster, not control or limit, competition, on the belief that a properly regulated competitive market, in any line of insurance, is essential to serve the consumer interest in accessible and affordable insurance. Each of our members shares that commitment.

The analysis of the competitive impact of the proposed consolidation

Sections 1402 and 1403 of the Insurance Holding Companies Act make competition the primary standard in reviewing this proposed consolidation.

Granted, those sections present some nuances in the standards for measuring the competitive impact of any consolidation, as with the appropriate product lines and geographic areas. We therefore request that the Department, as part of its review, disclose in advance of any closing of the public and legislative comment periods the standards it intends to apply for measuring the competitive impact of the proposed consolidation, and any statistics it is using to measure this impact. That will allow the public, including competitors, as well as the Senate and House Insurance Committees, the opportunity for meaningful comment on the threshold question in the Department's review.

Whatever the nuances, the clear thrust of Sections 1402 and 1403 of the Insurance Holding Companies Act is to preserve, not lessen, competition. The danger of lessened competition only gives way if the economies of scale or resource utilization are "substantial" and "cannot be feasibly achieved in any other way", with those economies producing public benefits that exceed the public benefits of maintaining a competitive market.

We believe, as smaller competitors to Highmark and IBC, that their proposed consolidation will have a real and lasting impact on the ability of other insurers (both those already here and those who might enter this Commonwealth or its various regions) to compete in the Highmark and IBC market areas.

Highmark and IBC officials have stated that the proposed consolidation won't have any competitive impact since they don't compete with each other now. That ignores the impact on potential competition, and the Department's analysis should include potential as well as actual competition.

Highmark and IBC currently do not compete as a matter of choice, as reflected in their now-expired 10-year agreement not to compete (an agreement that expired just as they announced their plan to consolidate). They are, however, potential competitors - in fact, we question the legality of their failure to compete now and the agreement behind it - and that potential competition will be lost, not just lessened, under this proposed consolidation. And while Highmark and IBC officials saying they have no plans to compete with each other, the Department should remember that plans (and officials) change.

Further, the same Highmark and IBC officials who claim the proposed consolidation won't have any impact on competition claim they are doing it to be more competitive. Given their market dominance in their respective regions, how much more competitive they could be is an interesting question; in any event, given that dominance, their intent to become even more competitive in their territories clearly has the effect of lessening competition from others.

We recognize that some commentators may not see an erosion of competition as something to be prevented; those who favor a single-payer system may view this proposed consolidation as a step along that road and therefore might focus only on possible means to control the consolidated entity as a veritable single payer.

We recommend the Department not lose sight of the need for competition in Pennsylvania's health insurance market. First, that is a clearly stated goal under Sections 1402 and 1403. Second, it is an essential component of a vibrant, consumer-oriented insurance market. The debate between advocates for a government-operated single payer system and advocates for a competitive insurance system is not the issue in this proposed consolidation. This consolidation raises the issue of whether a private monopoly is better to serve consumers' needs than a competitive market. The General Assembly has answered this question in favor of competition in its enactment of Sections 1402 and 1403, and Department needs to keep this at the forefront in its review.

Recommended conditions to which any consolidation of Highmark and IBC should be subject

We recommend that any order approving this proposed consolidation come with the following conditions. We believe these conditions are necessary to preserve a competitive market in Pennsylvania, and particularly the territories in which the proposed consolidated entity will operate in the Commonwealth. We also believe these conditions are necessary to ensure that the proposed consolidation, if approved, will provide meaningful public benefit.

Provider contracting

- Prohibit exclusive contracts and "most favored nation" or "prudent buyer" requirements. This should include prohibiting restrictions on providers from contracting with or joining networks of other insurers. We believe these contracts are prohibited now, at least to the extent they are subject to the Department's approval. This was part of the 1996 Highmark order, but only for three years; it should be permanent here.

- Prohibit loans, investments or any contributions to providers on the board(s) of the consolidated company or its subsidiaries, or to any providers or facilities in the network. We recognize that exceptions may, on occasion, be appropriate; we recommend any exception be subject to Department approval to ascertain that such loans, investments or contributions not be tied to rates or other contractual relations.

- Prohibit employees, officers or directors of the consolidated entity and all subsidiaries from having a position in any participating network or facility.

- Require transparency in provider contracts. The consolidated entity and all subsidiaries should disclose all provider reimbursements and other financial incentives, with that information available on-line.

Rating and underwriting restrictions

- Require Highmark/IBC and all subsidiaries to use community rating in groups of 50 or fewer employees, and require modified community rating in individual coverage. There should be specific focus on prohibiting predatory pricing or other forms of temporary under- or shifted-pricing to gain market share by Highmark/IBC and all subsidiaries.

- Require prior approval of all rates and underwriting practices by Highmark/IBC and all subsidiaries.

Marketing restrictions

- Prohibit Highmark/IBC and all subsidiaries from not allowing a group policyholder to offer coverage from other insurers.

- Require that Highmark/IBC and all subsidiaries share a group's claims and renewal information with the group and, upon request, with other insurers or producers. The information should go back three years (assuming they had the business that long) and be made available within 30 days of a request.

- Require restrictions on producer compensation. This should include a prohibition on excessive incentives tied to membership retention, with "excessive" being deemed more than 10% of standard compensation rates.

- Prohibit exclusivity requirements with producers or, in the alternative, prohibit compensation variations based on exclusivity (possibly with a 10% variation cap as with membership retention).

- Require marketing of all products throughout the Commonwealth and override BCBSA attempts at limiting this.

- Prohibit Highmark/IBC and all subsidiaries from entering into any non-compete covenants with other Blue plans or their subsidiaries. The 10-year non-compete covenant between Highmark and IBC appears to have been unprecedented in insurance corporate transactions. Although approved by the Department, it seems at least a presumptive violation of Section 5(a)(5) of the Unfair Insurance Practices Act and its prohibition of agreements "tending to result in unreasonable restraint of, or monopoly in, the business of insurance."

Social mission conditions

- Require annual accounting of social mission expenditures, with public notice and regulatory approval.

- Require a set amount for annual social mission expenditures. This was done in the 1997 order creating Highmark and in the 2005 CHRA for all Blues, with the amount equal to what premium taxes would be. The question is how to spend the funds; that may change depending on health care needs in Pennsylvania - but in no event should such spending be used to gain market share through temporary price cuts that will only erode market competition.

- Specify the appropriate social mission, particularly in recognition that the 2005 CHRA will expire soon. The social mission could be dedicated to funding CHIP and adultBasic, or government heath and wellness programs, and should require legislative involvement and approval. It should not be allowed for general promotional activities.

- Strengthen the open-enrollment requirements of being the alternative market mechanism. This should include greater public disclosure of the number of consumers being served under this mechanism and the premiums being charged versus the subsidies being provided.

- Require disclosure of the amount received by Highmark/IBC and their subsidiaries in transaction fees from insureds of other Blue plans receiving services from Highmark/IBC network providers, along with amounts paid by Highmark/IBC on behalf of their policyholders in transaction fees to other Blue plans. Any excess in the balance of these fees should be devoted to social mission purposes.

Surplus and financial conditions

- Require that "excess" surplus be disgorged and distributed to state health initiatives, not Highmark/IBC market enhancement, with a reexamination of what constitutes "excess" surplus under the Insurance Commissioner's 2005 order. As the Commissioner noted in that order, "excess" surplus is determined based on the size of the Blue - and the size of this Blue will be dramatically different than contemplated in that order.

- Impose limitations on investments. Limit investment in health insurance subsidiaries, both in-state and out-of-state, and both for-profit and non-profit, to the investment caps in Section 405.2(c) as revised in the recently passed House Bill 1150, but with the exceptions in Section 405.2(c)(2) not applicable. This will ensure that investments benefit the policyholders of Highmark/IBC, not its business ventures in other states.

Conditions on subsidiaries

- Require that such subsidiaries be subject to the same conditions as the Highmark/IBC parent. Otherwise, the parent is able to skirt whatever conditions the Department imposes by shifting funds and business to its (generally for-profit) subsidiaries.

Future transactions

- Prohibit Highmark/IBC from converting to for-profit status absent specific statutory authority. While officials of both companies claim to have no plans for imminent conversion, the Department should make clear that they may not convert to for-profit status unless the General Assembly enacts express legislation allowing this and providing the terms for it.

- Require prior approval of any shift of funds, business or internal allocation from Highmark/IBC non-profit operations to its for-profit operations, both in-state and out-of-state. This should include annual reporting on the balance of non-profit and for-profit business, as well as in-state and out-of-state business. Highmark and IBC officials have claimed this proposed consolidation will allow them to expand operations in other states. That is not the "public benefit" envisioned in Pennsylvania law, where the focus is on the Pennsylvania consumer.

- Prohibit any non-competition clauses or covenants in any such transactions or generally, among Highmark/IBC affiliates or with any other Blue plan or health insurer or ASO.

BCBSA conditions

- Prohibit participation in territorial allocation agreements among BCBSA members, in-state or out-of-state. This should include, as part of the review of the proposed consolidation, an examination of the terms and conditions in being part of the BCBSA. This association seems a largely unregulated and unaccountable body from state regulators that is able to reduce, control or eliminate not only competition from other Blue plans, but competition to Blue plans form other insurers. Such arrangements run afoul of the Unfair Insurance Practices Act and the goal of Sections 1402 and 1403 to preserve, not lessen, competition.

Again, these are preliminary comments and recommendations. We look forward to discussing them with the Department and other parties as part of then public hearings on the proposed consolidation, and we look forward to refining them as further specifics come in. Maintaining a competitive market is essential if this consolidation is truly to serve the consumers of Pennsylvania, and we believe these recommended conditions are themselves essential in achieving this goal.

Sincerely,

Samuel R. Marshall

C: Honorable Donald C. White, Chairman
Honorable Michael J. Stack, III, Minority Chairman
Senate Banking and Insurance Committee

Honorable Anthony M. DeLuca, Chairman
Honorable Nicholas A. Micozzie, Minority Chairman
House Insurance Committee

Honorable Tom Corbett
Attorney General

The Insurance Federation of Pennsylvania, Inc.

1600 Market Street
Suite 1520
Philadelphia, PA 17101
Tel: (215) 665-0500 Fax: (215) 665-0540
E-mail: mailbox@ifpenn.org

Samuel R. Marshall
President & CEO

July 15, 2008

Robert Brackbill, Chief
Company Licensing Division
Pennsylvania Insurance Department
1345 Strawberry Square
Harrisburg, PA 17120

Re: Supplemental comments on the proposed Highmark/IBC consolidation in advance of the July 16 hearing

Dear Mr. Brackbill:

This is to supplement our July 9 comments in advance of our oral presentation at the July 16 hearing.

The focus on competition: The Pittsburgh and Harrisburg hearings correctly focused on the impact the proposed Highmark/IBC consolidation would have on competition in the health insurance market in the affected territories within Pennsylvania in which the consolidated insurer would operate, and within Pennsylvania generally.

The general response from Highmark and IBC is that the consolidation would have little, if any, impact on competition because these two insurers - by far, the behemoths in Pennsylvania's market - don't compete with each other now and have no intention of doing so.

This raises a number of questions and issues for the Department. In fact, these responses are evidence of the competitive impact of the proposed consolidation and highlight the merit of the conditions we have recommended.

Highmark's CEO claims it doesn't and wouldn't compete in IBC's territory because that is a "very difficult marketplace" and therefore not one Highmark would "entertain entering". I'm not sure the Highmark CEO explained why he felt it was such a difficult marketplace, but I imagine it has something to do with the IBC dominance within its territory - a dominance built over time in large part because IBC has never faced competition from Highmark.

IBC's CEO claims it doesn't and wouldn't compete in Highmark's territory (and elsewhere in Pennsylvania) because it would be too distracting to its core business in the Philadelphia area and because it has good relations with the other Blues.

If nothing else, these remarks show that Highmark and IBC are at least potential competitors. There are no legal restrictions on their ability to compete - at least now that their unusual and unusually long agreement not to compete has ended - and it is not a restriction imposed on them by the Blue Cross Blue Shield Association. It is, apparently, purely a management decision.

Well, managements come and managements go, and managements change their minds; the same is true with good relations.

Both Highmark and IBC claim they currently face strong competition in their respective territories, so perhaps they will change their positions on the difficulty of entering the other's region. And as both insurers' CEOs have claimed, at least in their media tour, that one of the biggest benefits of the consolidation is their ability to expand out-of-state business, perhaps IBC is already rethinking its ability to focus outside its core area. Besides, should the consolidation be approved, it will have to broaden its focus anyway.

Further, the fact that a major reason Highmark and IBC don't now compete is because they like each other would be laughable if it weren't so troublesome. Insurers can have "good relations" with one another but still compete. And the insurance laws - particularly Section 5(a)(4) of the Unfair Insurance Practices Act - are intended to promote

competition and give the Department extensive powers in preventing anti-competitive arrangements and conduct.

Highmark and IBC are at least potential competitors, a potential that will be lost under the proposed consolidation; and they arguably should be current competitors - at the very least, the reasons they aren't should be more fully examined, because it should be based on more than the thought that the other's market is too difficult (that didn't stop Highmark from entering into Capital's territory) or "good relations."

Further, Highmark and IBC themselves have claimed that this consolidation will make them more competitive in Pennsylvania, not just in other states - or at least hold down their prices here, which in the cost-oriented world of health insurance is the key to competitive ability. There's nothing inherently wrong with a motivation to be more competitive - that should be a driving force in any business's decision, and it is a key to consumer benefits.

Highmark and IBC have tried to downplay this competitive goal in these hearings. That is probably because while becoming more competitive is a good thing in a normal market, it is a problem when the insurers looking to become more competitive by joining together already enjoy a dominant market share, because that only erodes the overall competition in the market.

Nonetheless, Highmark and IBC can't have it both ways - they can't claim no competitive impact, while claiming this will enhance their competitive status. The reality is that the difficult, albeit chummy, marketplace that the Highmark and IBC CEOs have cited will be that much more difficult for those who haven't had the advantage of enjoying good relations with the biggest insurers.

The focus on public benefits: The impact on competition isn't the only standard for reviewing the proposed consolidation. The public benefits of increased availability of insurance and unique economies of scale or resource utilization (unique in that they can only be

achieved through the consolidation) are also factors to be balanced against any loss of competition.

This consolidation won't make health insurance more available, so the only question is whether it produces unique economies of scale or resource utilization that outweigh the lessening of competition. We fail to see how that will happen in what Highmark and IBC both acknowledge is the regional business of health insurance, and we fail to see how that will be guaranteed and enforced.

In truth, an examination of Pennsylvania's insurance markets shows that the best way of ensuring efficiencies in the business of insurance is through a well-regulated, competitive market. That is certainly the case in every other line of insurance; the most prominent examples are homeowner and workers compensation coverages, where greater competition has spurred greater efficiencies among insurers - and with that, lower rates and more widespread availability for consumers.

The recommendations we set forth in our July 9 letter go to both of the standards that are the cornerstones of the Department's review: First, the recommendations are practical ones to ensure that the health insurance market remain competitive; and second, the recommendations ensure that whatever efficiencies emerge from this consolidation benefit Pennsylvanians.

The comments from Highmark and IBC at last week's hearings and in their media tour highlight the need to implement these recommendations if this proposed consolidation is approved.

Sincerely,

Samuel R. Marshall

C: Honorable Donald C. White, Chairman
Honorable Michael J. Stack, III, Minority Chairman
Senate Banking and Insurance Committee

Honorable Anthony M. DeLuca, Chairman
Honorable Nicholas A. Micozzie, Minority Chairman
House Insurance Committee

Honorable Tom Corbett
Attorney General

Insurance Federation remarks to the Insurance Commissioner - July 16, 2008 - Philadelphia hearing

Watching this on the webcam, I've noticed that many of those offering opinions have couched them in terms of whether the proposed consolidation is good or bad, or whether Highmark and IBC are good or bad.

But that's not the standard - the questions are whether the proposed consolidation lessens competition; and if so, whether it nonetheless will make health insurance more available and whether it produces sufficient - and sufficiently unique - benefits that should allow it to move forward.

Will the proposed consolidation lessen competition? Absent the types of recommendations we've set forth, the answer is yes. I'd have said that was self-evident until some of the remarks in these hearings.

Both Highmark and IBC, in their claims that it won't impact competition because they don't compete with each other now, have shown the danger of undue market concentration - the complacency and maybe even unintended arrogance that come with it.

Highmark says it is just too tough to compete with IBC - and IBC says competing with Highmark would ruin a beautiful friendship.

That's touching. But when the two biggest insurers say they can't compete with each other now, imagine how much tougher it will be for others when they merge - because they've both claimed this consolidation will make them even more competitive on their home turfs.

Fortunately, most insurers are not as intimidated by - or affectionate toward - one another as seen in the relation between Highmark and IBC. But you need to keep those other insurers in the market to keep competition viable, and to keep even the biggest of the Blues on their toes, and that's what our recommended conditions do.

I'd also like to address the argument that Highmark and IBC are so dominant in their respective markets now that the consolidation can't make things any less competitive.

Sure it can. First, you lose the potential of competition that these insurers bring to Pennsylvania. Managements, like corporate friendships, come and go - I suspect at one point in the past, Highmark and Capital were "BFFs", but now they are fierce competitors, to the benefit of consumers. Highmark and IBC could be - and probably should be - competitors, too.

Second, the sheer magnitude of the consolidated entity will dictate the nature of Pennsylvania's health insurance system. With the partial ownership Highmark now has with NEPA, this will turn Pennsylvania's market into almost a "one-horse town".

That's going to drive out the appetite of other insurers to invest the time and capital it takes to become viable competitors. However difficult it is for Highmark to envision competing with IBC, imagine if an insurer had none of the Pennsylvania institutional advantages that come from being Highmark.

Let's face it: Highmark and IBC aren't proposing this consolidation to consummate a friendship, and this isn't a case of "if you can't beat 'em, join 'em", since they've never tried competing with each other. And they're not doing this because the marketplace is forcing them to do so - their market shares in their own regions have been doing pretty well.

They are doing this to increase their dominance here, not just branch out into new areas. Such is life in corporate America. But that's one reason corporate life is so regulated: Because our laws recognize that competition is worth preserving and promoting.

Now let's turn to whether, even in the face of lessened competition, this consolidation would produce some unique benefits for consumers - benefits that would only occur if the consolidation goes through.

On the availability end, I don't see anything unique. In fact, given that some of the availability of insurance is

in Highmark and IBC continuing to fulfill their social mission, I think there are some problems.

Highmark and IBC have offered to continue fulfilling their social mission pledge set forth in the 2005 Community Health Reinvestment Agreement for at least a few years past its scheduled 2010 expiration date.

How nice - but why shouldn't that be a permanent obligation, as was set out 10 years ago when the Department approved the creation of Highmark?

I represent for-profit insurers, and people ask about our social mission contributions. We have one - it is called premium taxes. The ballyhooed "social mission" expenditures of Highmark and IBC are about what they'd pay in premium taxes anyway - they should at least be made a permanent condition, with some real transparency to make sure they are fulfilled every year.

I'm skeptical about grandiose projections of economies of scale, too, especially when compared with the dangers of lost actual and potential competition - because once you lose a competitive market, it is lost for good.

The irony in the "economies" argument is that, at various times, I've heard Highmark and IBC claim this consolidation will be great for economic development - that it won't hurt jobs in either shop and in fact will create new ones as they grow their markets here and elsewhere.

That may well be true. I represent many insurers that, however big on a national scale, don't have veritable monopoly status in any region and always face stiff competition from each other. As a result, we're like every other business in America, and sometimes even like government when it faces budget woes - at times, we have to go through tough rounds of budget and employment cuts.

Monopolies don't have to do that, probably why Highmark and IBC rarely pare back and why they see the consolidation as more of that same luxury but on a bigger scale.

I'm as in favor of employment as any other employee, but it sure does make that "economies of scale" and "newfound efficiencies" argument ring a little hollow.

The reality is that health insurance, after a certain point already long passed by Highmark and IBC, is a regional and labor-intensive business. Combining two insurers and their geographic regions won't make them any more efficient in those regions. For better or worse, they'll stay about the same - because only real competition will push them into the harsh choices that promote true efficiencies.

Some final observations: Over the years, we've probably been on the opposite side of Highmark and IBC as much as anybody, and they've shot a few arrows our way, too.

But this review shouldn't be a popularity contest. In fairness to both companies, they are good local employers and corporate citizens, and whatever happens with this proposed consolidation, they'll remain that way.

This review should be about ensuring - to the best of the abilities of the regulatory process - that consumers and providers in Pennsylvania still have some options out there, that even a dominant insurer still feels the pressures of the marketplace, and that savings promised are savings realized.

With all deference to your experts and to a regulator's tendency to pronounce its crystal ball the most accurate of all, nobody can answer these questions with absolute certainty.

But everybody can make some reasonable and responsible projections about the impact of this consolidation - and through that, the Department can develop some reasonable and responsible conditions should it allow this consolidation to go forward.

We've offered a number of them. They're offered not to block the consolidation, but to ensure what I've talked about in our comments and today - that when all is said and done, consumers and providers need some choices, the big boys need some pressure, and promises of savings need to be kept.

United States Senate Committee on the Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights

Public Hearing

Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription?

July 31, 2008

Testimony by Kenneth R. Melani, M.D.

President and Chief Executive Officer

Highmark Inc.

My name is Dr. Ken Melani, and I am president and chief executive officer for Highmark. With me is Joe Frick, the president and chief executive officer for Independence Blue Cross. We want to thank the Committee for the opportunity to speak to you today about why the proposed combination of Highmark and Independence Blue Cross into a new company is good for Pennsylvania and how it will create value for the communities in which we operate, for our customers, for health care providers and, most of all, for the people of Pennsylvania.

Since we spoke to the Senate Judiciary Committee in April 2007, we have been engaged in an extensive review process involving state and federal regulatory agencies, with input from state and federal public officials. This is an important, cooperative and open process. Today, we continue this open dialogue about how this combination will better serve the needs of the people of Pennsylvania.

Our companies have a proud tradition of serving Pennsylvania as non-profit companies. For 70 years, IBC and Highmark have had a common mission: to help ensure that health care is available, affordable and of high-quality for all Pennsylvanians.

Throughout our history, we have made health insurance programs available to everyone, regardless of age, gender and health status. We have provided assistance to people in financial need, by subsidizing health insurance programs for children, lower-income individuals and families, and older adults. Moreover, we have provided financial support for health education and community health programs.

At the same time, according to a study performed by a market research firm, Tripp-Umbach, Highmark and IBC have had a significant, positive impact on Pennsylvania, with a total annual economic impact of $4.2 billion on the state's economy. The companies employ approximately 18,000 people in high-quality jobs in the state and purchase a significant amount of goods and services from Pennsylvania-based businesses.

This transaction, however, is not about the past or the present. It is about the future and about preserving our non-profit status. And it is about laying the foundation for positive change in the way health care is delivered and paid for in Pennsylvania. Coming together, our two companies can remain a financially vibrant Pennsylvania-based company and achieve tangible savings and growth opportunities of more than $1 billion that will be used to address health care costs, quality and access to medical care in Pennsylvania.

This combination will also allow us to strengthen our contribution to the Pennsylvania economy – by the way we employ people, by creating new businesses opportunities for Pennsylvania-based businesses and by supporting the community through programs and services that we have historically embraced.

The proposed combination is important given the challenging health environment. Health care costs are rising dramatically. We know that the cost of health care is making health insurance less affordable for businesses today. As a result, fewer businesses are able to maintain health care coverage and more people are joining the ranks of the uninsured. We are also seeing more people moving to public health insurance programs, which means more health care coverage is being financed through the federal and state governments.

The demographics of Pennsylvania also present challenges. The state has an aging population that is creating more demand for health care services. We also have an aging workforce in many industries, including health care. This places an added strain on the health care system as the aging population uses more medical services. Questions are also being raised about the quality of health care today and the variation in medical care from community to community for people with the same medical condition.

With these critical issues facing us across Pennsylvania and nationally, rapid change is occurring in health care. Consumers are taking greater responsibility for their personal health care decisions and their costs. This change is creating the need for investments in technology so people can access their own personal health information and have programs available to better manage their own health.

As these forces shape health care, two points have become very critical to business success. First, scale has become increasingly important to achieve greater efficiency and lower administrative costs. The scale of competition has shifted from a local to a regional and national basis. We have a growing need to be a multi-product, multi-market company to compete in the future, to spread our risks and to better serve our customers. Second, there is a growing need for capital for investments to meet the marketplace demands that we outlined earlier.

The health insurance industry is responding by consolidating. In the past 15 years, the top 20 insurers have substantially increased their share of subscribers in the commercial health insurance market. Even more significant, during the same period, large, well-capitalized for-profit insurers have gained a much larger share of commercial health insurance subscribers compared to non-profit health insurance companies.

The largest players in health care today are WellPoint, United HealthCare, Aetna and CIGNA with anywhere from 13 million up to 35 million subscribers. They have the scale, the product diversity and the geographic diversity to spread their operating costs over more members. They also can leverage their large subscriber base to obtain better pricing from national suppliers of laboratory services, durable medical equipment, radiology services and pharmaceuticals. In contrast, Highmark and IBC, combined, have eight million subscribers.

Consolidation isn't unique to the for-profit health insurance companies. It's happening in the Blue Cross and Blue Shield system in the United States as well. Today, there are 39 independent Blue Cross and Blue Shield companies. That is one-third the number since 1980, when there were 115 Blue Cross and Blue Shield companies. In fact, some Blue Cross and Blue Shield companies operate in multiple states. These companies have gained operating efficiencies and can better serve their customers.

Pennsylvania stands alone in that we have four independent Blue Cross and Blue Shield companies. This is problematic because we are operating less efficiently than we could be by investing in redundant technologies and capabilities that add more cost to the state's health care system.

As the two companies have looked at the changing health care environment and the need for greater scale and more capital, it has become clear that the combination of IBC and Highmark is a natural fit that would bring significant benefits to the people of Pennsylvania. The two companies have almost identical missions and have worked together for over 50 years to better serve the community, through programs like the Caring Foundation. We also have complementary products. Highmark's vision, dental and stop loss lines of business complement IBC's pharmacy benefit management, third-party administration and workers compensation programs. Together, our two companies can offer a core blend of products to better serve our customers on a common platform.

What's most important is that bringing our companies together will not lessen competition in commercial health insurance or reduce choice in any market in Pennsylvania in the future. Our subscribers will continue to have the same wide variety of choice from a competitive health insurance market as they have today. Although over 100 witnesses appeared at the recent Pennsylvania Insurance Department hearings – and many others have filed comments with the Insurance Department – we are not aware that any of our over 50,000 commercial group customers have complained that they will have less choice for insurance the day after the transaction than they have today.

And lastly, the United States Department of Justice has twice reviewed the proposed consolidation of the two companies and both times cleared the transaction under federal antitrust law.

Thank you.

TESTIMONY OF HENRY MILLER, Ph.D.

ON BEHALF OF UPMC HEALTH PLAN

JULY 31, 2008

Presented to: Senate Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights

My name is Henry Miller. I am a Managing Director in the health care practice of Navigant Consulting, Inc. I have worked on health insurance and health finance issues for more than thirty years, including work for clients based in Pennsylvania, in other states and for the Federal government. My work in Pennsylvania has included projects conducted for Highmark, Inc., Blue Cross of Northeastern Pennsylvania, Coventry Health Care, the Commonwealth's Medicaid program and other agencies within the Department of Public Welfare. My work for the Federal Government has included projects for the Centers for Medicare and Medicaid Services as well as most other Federal agencies that are concerned about healthcare. My work in other states includes my analysis of the application of Premera Blue Cross to convert to for-profit status which was undertaken for the Alaska Department of Insurance. I have also conducted projects for Blue Cross and Blue Shield plans in twenty seven states as well as several other health insurers. My curriculum vita has been submitted separately.

I was asked by UPMC Health Plan to analyze the impact of the proposed consolidation of Highmark, Inc. (Highmark) and Independence Blue Cross (IBC) and to testify today on my findings. UPMC is an integrated delivery and financing system and the second largest non-governmental employer in Pennsylvania. UPMC Health Plan provides commercial group coverage to over 6,000 employers with approximately 330,000 members, Medicare and Medicaid coverage to another 185,000 beneficiaries, and services an additional 700,000 members through a variety of other benefit programs such as behavioral health, CHIP, short term disability, employee assistance and wellness programs.

I have prepared a detailed report for UPMC Health Plan of the impact of the proposed Highmark/IBC consolidation. I can deliver a copy of my detailed report to this Committee upon request. Today, I will concentrate on four issues:

- Antitrust concerns and the markets that will be affected by the proposed consolidation. Here, the combined entity will control more than two thirds of the state's commercially insured residents.
- Previous health insurer consolidations have not led to administrative savings.
- Pennsylvania's hospitals will be adversely impacted by the increased financial pressure that will result from the combined entity's leverage during hospital contract negotiations.
- The proposed consolidation will adversely change the market for health insurance in Pennsylvania to the detriment of healthcare consumers and providers.

It is important to understand that the commercial managed care market is not a single market. A market requires products to be substitutable, i.e., a purchaser can evaluate all products that are available in the market and can select from among them. A Pennsylvania consumer seeking to purchase health insurance does not have access to all commercial managed care products. There are, in fact, three markets for health coverage and when each of the markets – the market for individual coverage, the market for small group coverage and the market for large group coverage are examined separately, it is clear that, for some customers, these health insurance markets operate on a statewide basis. Of course, there exist additional markets for behavioral health programs and ancillary products but I am focusing primarily on group and individual physical health products today.

Understanding that the health insurance market operates for some customers on a statewide basis is important because the consolidation of Highmark and Independence Blue Cross will create a single entity that will have a dominant market share in the state. In 2006, Pennsylvania's population was 12,345,000.[1] 1,986,000 of these residents were covered by Medicare[2] and 1,473,000 were covered by Medicaid.[3] In addition, Pennsylvania had 1,237,000 uninsured residents.[4] The commercial insurance market therefore included 7,649,000 residents[5]. Highmark provided coverage to 3,362,944 of these residents (44.0 percent).[6] IBC provided coverage to 1,899,740 residents (24.8 percent).[7] On a combined basis, Highmark and IBC provided coverage to 68.8 percent of the Pennsylvania commercial health insurance market.

When considering a merger or consolidation, it is important to determine who will benefit. Reduced administrative costs are a commonly cited benefit of a consolidation. Although this benefit is cited frequently, it is important to understand that few, if any, health insurance company mergers in the past ten years have resulted in lower administrative costs. The complexity of health insurer operations and their reliance on information technology has meant that administrative savings have been elusive.

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[1] U.S. Census, Current Population Survey for Pennsylvania, 2006. (pubdb3.census.gov/macro/032007/health/h05_000.htm)

[2] Ibid.

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Hospital & Health System Association of Pennsylvania, The Pennsylvania Department of Insurance, The Pennsylvania Department of Health.

[7] Ibid.

In 2007, I served as the financial consultant to the New Jersey Commission on Rationalizing Health Care Resources. The commission was established by Governor Corzine to address concerns about the financial instability of many of the state's hospitals. My review of hospital finances in Pennsylvania raises similar questions about hospitals' ability to withstand increased financial pressure. Pennsylvania hospitals have lower margins, less liquidity and are less able to cover their existing debt than the average U.S. hospital. More importantly, Pennsylvania hospitals have physical plants that are more than 14 percent older than the plant of the average U.S. hospital. The consolidated Highmark/IBC entity will have extraordinary leverage in hospital contracting at a time when hospitals are considerably less able to withstand that leverage.

Because of their size, Highmark and IBC already have significant competitive advantages in the Pennsylvania market. Their advantages are evidenced by the difficulty other health insurers have in competing in Pennsylvania as compared to other states. If the consolidation is approved, the combined entity will provide coverage to at least two-thirds of Pennsylvania's residents and have financial resources that will be used to further increase that already-substantial market share. Consolidation will certainly not make it easier for other health insurers to compete in Pennsylvania, and will likely make such competition even more difficult than it is today. Furthermore, no meaningful benefits will accrue to the residents of Pennsylvania that offset the impact of the resulting decline in competition.

Statement of The Hospital & Healthsystem Association of Pennsylvania

Before the United States Senate Judiciary Committee
Subcommittee on Antitrust, Competition Policy and Consumer Rights
"Consolidation in The Pennsylvania Health Insurance Industry: The Right Prescription?"

Presented by

Carolyn F. Scanlan
President and Chief Executive Officer
The Hospital & Healthsystem Association of Pennsylvania (HAP)

Washington, D.C.
July 31, 2008

Introduction

Chairman Kohl, Senator Specter, and other members of the committee, I am Carolyn F. Scanlan, President and Chief Executive Officer for The Hospital & Healthsystem Association of Pennsylvania (HAP). HAP represents and advocates for the more than 250 acute and specialty care hospitals and health systems across the state of Pennsylvania, and the patients they serve. I appreciate the opportunity to present the views of hospitals and health systems across Pennsylvania regarding the proposed merger of Highmark, Inc. and Independence Blue Cross.

Over the past year, HAP has raised questions and concerns with both federal and state officials regarding the proposed merger of these two plans and has called for a thorough review by government. Through HAP's public policy development process, we have evaluated the information provided by the two plans to the Pennsylvania Insurance Department, reviewed other information publicly available about health insurance markets and practices, and carefully considered the hospital community position on the proposed merger of Highmark, Inc. and Independence Blue Cross.

Based on the available information and after thorough discussion, the hospital community in Pennsylvania opposes the merger of Highmark, Inc. and Independence Blue Cross as proposed. The current health insurance marketplace in Pennsylvania already is skewed toward Highmark, Inc.'s and Independence Blue Cross' advantage, and a merger would create a health plan with an overwhelming presence or "footprint" across the commonwealth.

Therefore, we believe that it is imperative that government not approve the merger as proposed. Should approval be granted, hospitals and health systems call for strong conditions and parameters, as well as strengthened state oversight and ongoing accountability be established to address market competition, fair and appropriate insurance contracting practices, and continued

community and social commitments. To that end, we were disappointed that another early termination was granted to the plans under the Hart-Scott-Rodino Act, without the federal government establishing any parameters.

Because of the interrelationship of the issues in this merger, my written testimony includes a discussion of each of the four major areas of concern. However, my remarks today will primarily focus on those issues that we believed merited a more thorough review at the federal level.

Perspective on Pennsylvania's Health Insurance Market

Based on data from several public sources, including the Pennsylvania Insurance Department, the Pennsylvania Department of Health, the Pennsylvania Department of Public Welfare, and the Centers for Medicare and Medicaid Services, statewide Blue plans have an estimated total market share of 79.5 percent—that is, nearly 80 percent of Pennsylvanians with insurance coverage (such as commercial PPOs and point-of-service, HMOs, Medicare managed care, and Medicaid managed care) access care through a Blue plan. When looking closer at this data, the majority of this enrollment is in the state's two largest Blue Cross plans. If these two plans merge, their combined market share will be approximately 65 percent (see attached chart for more detail).

In addition, in looking at available public data across the three major types of managed care enrollment (commercial, Medicare, Medicaid), one also sees that the Pennsylvania's Blue plans have approximately 51 percent of the market share of commercial managed care enrollment; 60 percent of Medicare managed care enrollment; and 59 percent of Medicaid managed care enrollment. Thus, while there may be many types of managed care insurance products offered in Pennsylvania, enrollment is predominantly in Blue plans.

Therefore, the proposed merger of Highmark, Inc. and Independence Blue Cross will create the largest private health insurer in Pennsylvania. The resulting plan will have an even more dominant impact on health insurance practices across many product lines in communities across the commonwealth.

The triggering event for governmental review is the proposed merger of these two plans. It is imperative that government—both state and federal—carefully evaluate this merger, particularly the resulting market power that the merged plan will have, as well as the potential for future monopsonistic business practices given the size of the merged plan and its overwhelming market penetration across the commonwealth.

Market Competition

Market competition in health insurance is important in achieving competitive premiums for employed groups and competitive payments to health care providers. Both Highmark, Inc. and Independence Blue Cross already enjoy a dominant position in their respective service areas. In addition, the relationship between Highmark, Inc. and Blue Cross of Northeastern Pennsylvania would enable the merged plan to account for a majority of commercial premiums in the commonwealth, providing it with even greater market power. Such power could make it that

much harder for existing health insurance competitors to expand their market share or for new competitors to enter Pennsylvania's health insurance market.

The stimulation of health insurance market competition should be a top priority for government, particularly state legislative or regulatory approaches that enable small group market reform to foster growth of affordable health insurance options for smaller employed groups.

At the same time, the merged plan will account for a majority of the commercial revenues of most hospitals and physicians in the state. Given the resulting market power of the plan, it could drive provider reimbursement levels below competitive levels needed to sustain the provision of quality health care to the citizens of the commonwealth.

Based on publicly available data, experience has shown that in the regions of the state—the south central and Lehigh Valley areas—that have more robust health insurer competition (multiple Blue and commercial health insurer plans) there has been a more stable hospital financial picture over time. (See attached charts that compare hospital financial status by Blue Cross plan service areas.)

Certainly, health care providers recognize the inadequacies of governmental financing through Medicare and Medicaid, but in certain regions of the state the financial stability of hospitals also has been impacted by a less robust commercial health insurance market. A dominant plan can also cause payments to providers to be suppressed below an appropriate level, and particularly for hospitals, this suppression can impact payment by Medicare, particularly through Medicare's calculation of what is called an area wage index. Data that was recently released by the U.S. Labor Department showed that among similar sized metropolitan areas, salaries for nurses in the Pittsburgh area were generally much lower. This type of factor impacts calculations for Medicare and creates a difficult cycle for providers seeking to recruit and retained qualified health care professionals.

Thus, a key policy question for government is how much of health care providers' (either facilities or practitioners) revenue should be controlled by one plan either directly or through such agreements that exist with Blue Cross of Northeastern Pennsylvania. We do not believe that this policy question has been addressed in the plans' filings regarding the Statement on Competitive Standards at the state level, and question whether this issue was addressed in the federal review.

The plans have stated that the change of control of the domestic insurer subsidiaries "will not substantially lessen competition or tend to create a monopoly in the lines of insurance in which those entities engage." However, this statement fails to address the potential for the Highmark, Inc./ Independence Blue Cross merger to create monopsony power in the market for the purchase of health care services, particularly hospital and physician services. This purchasing power could pose a risk that could adversely affect health care practitioners, hospitals—which in addition to providing needed care also significantly contribute to the economic vitality of community—and ultimately consumers seeking access to quality health care across the commonwealth.

Monopsony power is the ability to decrease prices paid to producers who have little opportunity to sell other than to the monopsonist. Most hospitals are confined to supplying services, as specified under their license, within a geographical area, and cannot do something else in response to reduced reimbursement other than to close services or close the hospital. Hospitals cannot move to more favorable markets.

Similarly, physicians are confined to supplying services within their training and scope of practice (licensure) laws and cannot do something else in response to reduced reimbursement other than relocating their practice.

This merger should raise competitive concerns—that is, whether the new company has a greater potential to eliminate rivals or competitors and/or whether through its new more dominant position it gains a greater ability to influence prices. Suppose the new plan reduces reimbursements to hospitals and/or physicians. Given the new plan's market share, do providers have the ability to terminate or even credibly to threaten to terminate the contractual relationship? That ability depends upon the provider's ability to replace the potential business/revenue that would be lost from contract termination and the time it might take to replace that loss. For physicians and hospitals this obviously would be quite difficult.

Further, monopsony power can harm consumers. If physicians, due to anticompetitive pressures, relocate to other markets outside of Pennsylvania, then access to physician care, which is already strained in many communities across the commonwealth, will be jeopardized. Further, physicians and hospitals that receive inordinately lower reimbursement may be forced to do more with less. This can result in longer waiting times, reduced staffing, or other cost reductions that could ultimately impact quality of care.

The concerns hospitals and physicians raise regarding monopsony power have not been properly analyzed and evaluated and serve as the center of HAP's concerns regarding the impact this merger will have on health care providers across the commonwealth.

The purpose of governmental oversight is to prevent the abuse of market power. Therefore, it is imperative that the government oversight properly evaluate the concern regarding monopsony power and take necessary actions, including:

- Explicitly prohibiting contractual provisions that raise competitive concerns—such as "most-favored" nation (or prudent purchaser, etc.) and/or "all products clauses" in any form that tie commercial, governmental (Medicare and/or Medicaid) and other product lines in a single contract.

- Review the existing agreement between Highmark, Inc. and Blue Cross of Northeastern Pennsylvania to limit control by the merged plan.

- Advance legislation that permits joint negotiation by providers through state action exemption to ensure Pennsylvanians continued access to quality health care.

Provider Contracting

Hospitals and health systems, as well as groups and/or individual practitioners, negotiate contracts with health insurers. These contracts cover many provisions affecting the purchase of health care, including quality, payment, credentialing, etc.

A dominant plan can deploy a "take it or leave it" approach with little or no opportunity for meaningful negotiations between individual providers—either facilities or practitioners. Given the market power and vast footprint that the merged plan will have, it is unlikely that hospitals or physicians who serve patients could "walk away" from the terms dictated by the plan.

Therefore, given the magnitude of market power of the merged plan, there need to be appropriate parameters—e.g., checks and balances—so that there isn't unchecked use of market power in these negotiations. Failure to establish effective parameters could unduly drive down provider reimbursement to inadequate levels, thus jeopardizing access to quality health care and the long-term financial sustainability of essential community health care services.

To enable a balance in the important partnership that exists between health insurers and the providers serving patients in communities across the commonwealth, government should consider the following parameters:

- Prohibition of use of unilaterally imposed contract terms by the merged plan, including use of most-favored nation or similar clauses that require the largest volume plan to be given the lowest rate by a provider, and/or contracts that require acceptance of all product lines sold by the merged plan. These prohibitions must include both commercial and public sector product lines.

- Allowance for a provider-initiated, binding, mandatory independent alternative dispute resolution process (such as arbitration) between health care facilities and/or provider practices and the merged plan to resolve contract disputes. Such an approach should specify the basic criteria that would be used and include confidential review by the third-party of data regarding payments to comparable providers (by size, service area, and/or nature of service of services provided) during the relevant time period during which the contract is in dispute, and the structure and process of the dispute resolution process. In addition, certain key financial indicators (such as margins, burden of indigent and uncompensated care, dependence on public payors—such as Medicare and Medicaid, capital investment support, quality and patient safety initiative support, etc.) must be considered during the dispute resolution process. Financial indicators used should be based on valid and reliable sources, such as data collected by state agencies.

- Enabling clinically and financially integrated organizations (either currently in existence or in the future as consistent with federal law) to negotiate as a unit with the merged plan. Federal authorities (Department of Justice and Federal Trade Commission) have long recognized the ability of financially integrated organizations to jointly negotiate contracts with health plans provided that the financial integration provided strong incentives for the providers involved to control costs and improve quality. More recently, federal

authorities through the 1996 *Statements of Antitrust Enforcement Policy in Health Care* have been evaluating clinical integration in matters related to antitrust policy. Clinical integration involves providers working together in an interdependent fashion so that they can pool infrastructure and resources, and develop, implement, and monitor protocols, "best practices," and various other organized processes that can enable them to furnish higher quality care in a more efficient manner than they likely could achieve working independently.

Criteria for clinical integration can include:

- Selectively choosing program physicians who are likely to further the program's efficiency objectives;
- Establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; and
- Significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

Hospitals and health systems appreciate the letter sent by several members of this committee in June 2007 (attached) to the Federal Trade Commission and the Department of Justice urging them to work with the hospital field to develop better guidance on clinical integration. It is imperative that federal officials continue to advance these discussions and we would request that this committee seek clarification on the status of these discussions with officials at the Federal Trade Commission.

Social and Community Mission

Pennsylvania's hospital plan and professional health service plan corporations were created by state statute in the late 1930s, for the purposes of enabling all Pennsylvanians to have access to coverage for hospital care and physician and other related services. Hospital plan corporations (e.g., Blue Cross plans) in Pennsylvania are statutorily mandated to be "benevolent and charitable" organizations and the professional health service plan corporation (e.g., Blue Shield plan) is statutorily mandated to have a "social mission," including meeting requirements for open enrollment, continuity of coverage, and low-income programs.

Continued fulfillment of the social mission and community obligation by the merged plan remains as important to Pennsylvanians today in assuring access to health coverage as it was when the plans were established in the late 1930s. Therefore, it is imperative that the continuation of these obligations be clearly specified in any state level agreement that permits the merger of these two plans. These specifications should address:

- Maintenance of not-for-profit status for a mandated period of time—ideally 20 years—to assure continued social and community mission and opportunity for plan/provider relationships/partnerships that are focused on improving the quality, safety, and affordability of care.
- The continuation of financial support for health insurance programs for the uninsured for the same period of time.

- Clarification that community mission includes reinvesting in the community through use of accumulated reserves to assure that assets stay in the region in which they are created and that community reinvestment includes partnerships with hospitals and practitioners in improving quality, safety, effectiveness, and health information technology.

Health Insurer Accountability

I'd also like to provide the policy framework by which the hospital community evaluates insurer accountability. Hospitals and health systems recognize that having health care coverage assures better access to care for individuals. We also believe that fair competition in health insurance:

- Enables consumers to have choice.
- Fosters affordability and innovation of employment-based insurance at reasonable premium prices.
- Enables fair and appropriate payments to providers delivering cost-effective, quality health care.

The Pennsylvania Insurance Department is responsible for oversight of Pennsylvania-domiciled insurers and must maintain the confidence and trust of Pennsylvania citizens that such oversight assures access to affordable health care coverage, as well as assuring that health insurers engage in appropriate and fair insurance practices.

Hospitals and health systems believe that there is compelling public policy interest for the state, through the Insurance Department, to assure that:

- There is a competitive insurance market that enables broad access to coverage.
- Health insurance practices foster efficient utilization and stewardship of limited resources.
- Health insurance practices enable access to high quality health care.
- There can be innovation in health insurance to respond to purchaser and subscriber needs.

We also believe that health insurer accountability, like delivery system accountability, requires greater openness, including public reporting of data that enables better information for consumers, purchasers, government, and health care providers. There need to be clear reporting requirements to enable ongoing review of the merged plan, including performance by product lines and evaluation of surplus and reserves. Reporting by health insurers needs to be consistent across plans and provide a complete picture of the financial and enrollment performance of all plans.

I might note that in our efforts to evaluate the proposed merger, it was quite difficult to evaluate data that is publicly available regarding health insurers. We have learned that there is not necessarily consistent or complete information across all types of health insurers or across the various product lines (commercial, Medicare, and Medicaid) that is available publicly for independent analysis of a consolidated entity's financial performance, enrollment, and utilization.

Therefore, we have called on the state to require the merged plan, as well as all other health insurers, to report in a consistent and complete manner to the Pennsylvania Insurance Department as part of accountability and transparency. In addition, average provider payments should be reported to the state's central health care data repository (hopefully a reauthorized Pennsylvania Health Care Cost Containment Council). Clear reporting requirements that are adhered to will support improved information for employers, consumers, labor, and others seeking to improve purchasing of coverage.

Also, while we applaud the Insurance Department's approach to making as much information about the proposed merger available to the public, it is unclear how and whether the department determined information deemed "confidential and proprietary" by Highmark, Inc. and Independence Blue Cross merited such secrecy and privacy. This flies in the face of consumers' desire for greater transparency and information. All assertions by the plans that the merger will create savings for the citizens of the commonwealth must be documented, and the use of those savings must be defined and documented as well.

In addition, accountability should exist across all types of health insurers and all product lines. The state's Quality Health Care and Protection and Accountability Act (Act 68 of 1998) defines payment policies across managed care plans (e.g., HMOs) regardless of ownership, which use primary care gatekeepers. Importantly for providers, this act established timely claims payment and utilization review standards. However, this type of managed care plan is not how most Pennsylvanians access health care and these accountabilities are not necessarily required across the other types of insurance products used in our state. Hospitals believe these accountabilities need to exist across all types of health insurers, including the proposed merged plan, to ensure timely payment to providers and that there are fair standards for utilization review of claims.

Finally, should state government approve the proposed merger, there need to be clear criteria and/or methodologies for ongoing monitoring and evaluation of the merged plan's compliance with commitments stipulated in any agreement reached with the Pennsylvania Insurance Department and/or the state Attorney General. This would include clear requirements for the plans in documenting that the savings attributed to the proposed merger were achieved and validating such documentation through an audit under state agency control.

Conclusion

A vibrant insurance market, which offers an array of affordable health plans to employers and consumers, supports access to quality health care for patients, and enables fair and appropriate payment practices for providers, is important. These are the issues that hospitals and health systems in Pennsylvania believe need to be balanced in evaluating potential changes to insurance in our state, including the proposed merger of the state's two largest Blue Cross plans.

Thank you for this opportunity to testify and to provide the Pennsylvania hospital and health system community's perspective on the proposed merger of Highmark, Inc. and Independence Blue Cross. I welcome your questions.

# # #

United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510–6275

June 7, 2007

The Honorable Deborah Platt Majoras
Chairman, Federal Trade Commission
Federal Trade Commission
600 Pennsylvania Avenue, N.W.
Washington, D.C. 20580

The Honorable Thomas Barnett
Assistant Attorney General
Antitrust Division
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530

Dear Chairman Majoras and Assistant Attorney General Barnett:

We are writing to urge you to work with the hospital field to develop better guidance for hospitals, physicians and other health care providers on undertaking clinical integration programs that have the potential to significantly improve the quality of care for patients across the nation.

Promoting efforts to improve the quality of health care for all Americans is a goal that all of us share. We appreciate that the Federal Trade Commission has devoted a good deal of attention to the issue of how competition can improve the quality of health care and lower its costs. To that end, the first recommendation in the 2004 FTC/DOJ report on *Improving Health Care: A Dose of Competition* was: "Private payors, governments and providers should experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements, and innovation." Clinical integration is one such effort that has the potential to achieve these goals for consumers.

The FTC could make a significant contribution to furthering clinical integration by working with the hospital field to provide guidance to providers who are eager to undertake clinical integration programs. The success of the *Statements of Antitrust Enforcement Policy in Health Care* in addressing providers' concerns about the requirements of the antitrust laws, suggests that a similar effort that is more focused on clinical integration would be of substantial benefit to providers as they explore innovative approaches to improving quality and lowering the cost of health care.

Thank you for interest in this important matter.

Sincerely,

HERB KOHL

ARLEN SPECTER

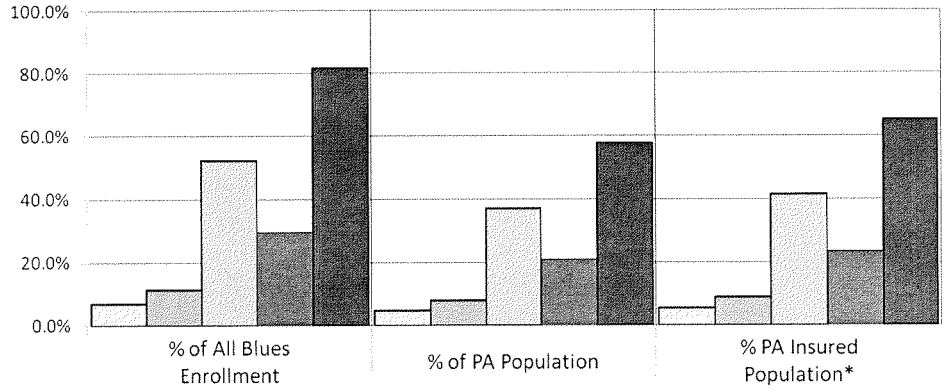
CHUCK GRASSLEY

RICHARD DURBIN

SHELDON WHITEHOUSE

Pennsylvania Blues' Market Share Analysis

(CY 2007 covered lives)



	% of All Blues Enrollment	% of PA Population	% PA Insured Population*
BC-NEPA	6.8%	4.8%	5.4%
Capital BC	11.4%	8.0%	9.0%
Highmark	52.3%	37.0%	41.6%
Independence BC	29.5%	20.9%	23.5%
Post-Merger (NewCo)	81.8%	57.9%	65.1%

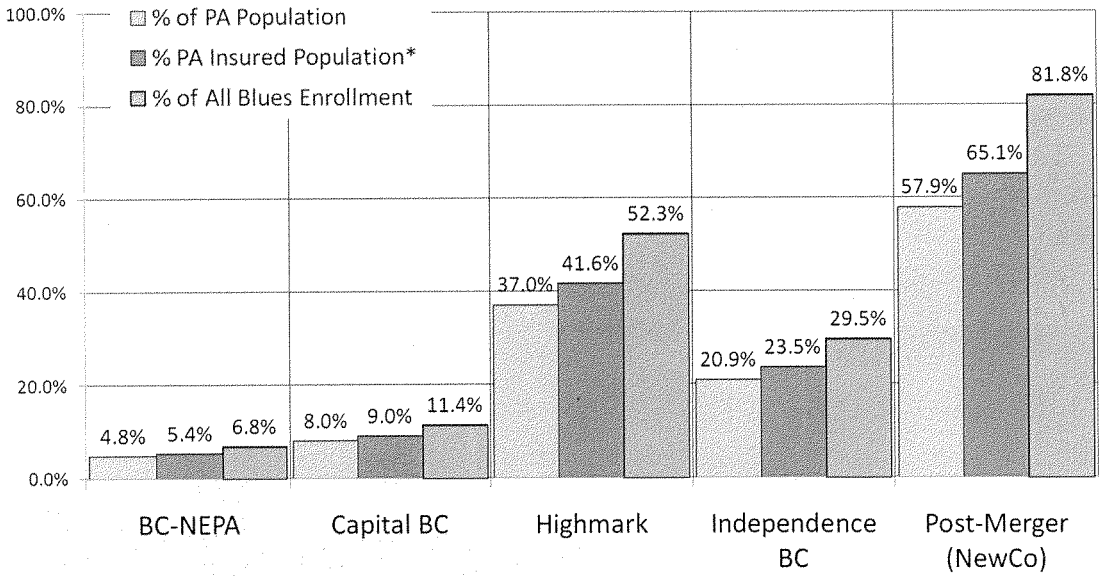
*** Total PA Resident Population less 2007 uninsured estimate for Pennsylvania (US Census).**

Source: PA Insurance Department & PA Department of Health

HAP

Pennsylvania Blues' Market Share Analysis

(CY 2007 covered lives)



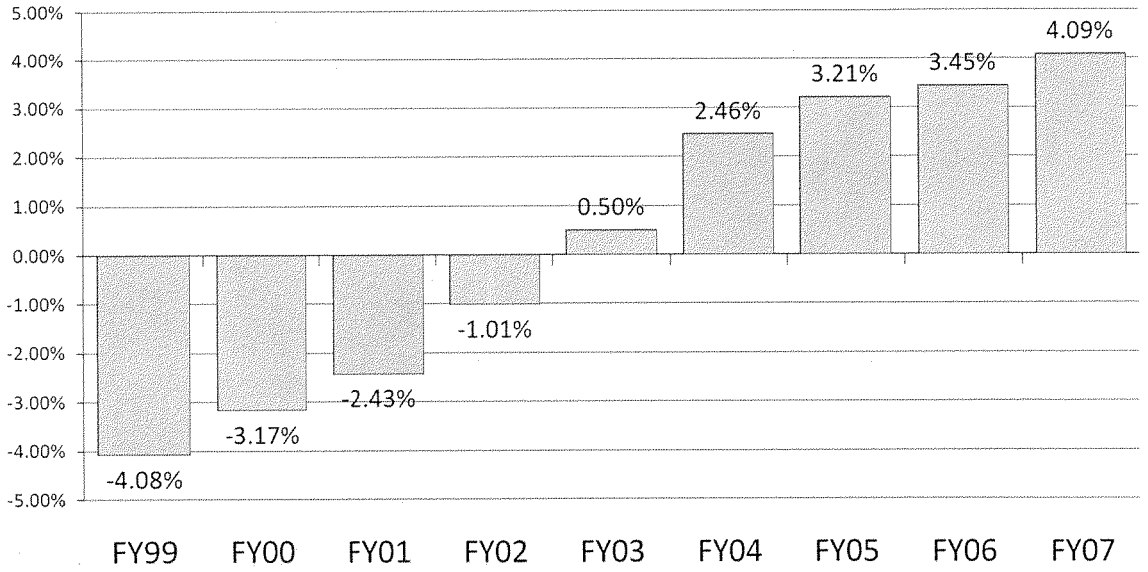
*** Total PA Resident Population less 2007 uninsured estimate for Pennsylvania (US Census).**

Source: PA Insurance Department and PA Department of Health

HAP

Patient Care Margins*

Central Pennsylvania



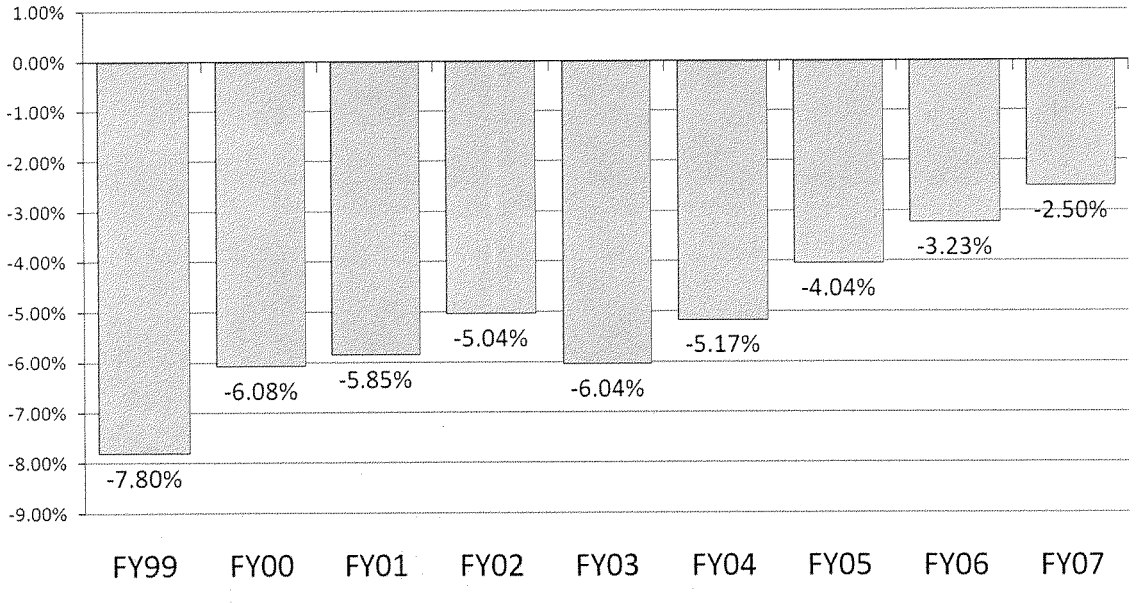
***General Acute Care Hospitals in Central (Capital Blue Cross) Region**

Source: Hospital margins (1999-2006) from HAP analysis of PHC4 data, Hospital margins (2007) HAP Financial Survey

HAP

Patient Care Margins*

Northeastern Pennsylvania



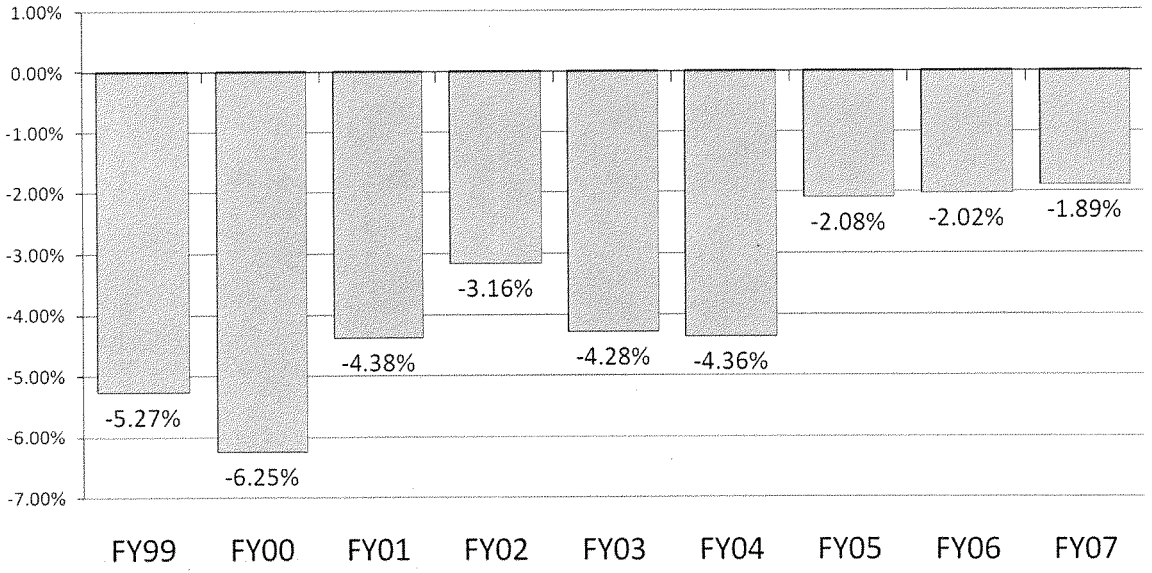
***General Acute Care Hospitals in Northeast (BlueCross of NE-PA) Region**

Source: Hospital margins (1999-2006) from HAP analysis of PHC4 data, Hospital margins (2007) HAP Financial Survey,

HAP

Patient Care Margins*

Western Pennsylvania



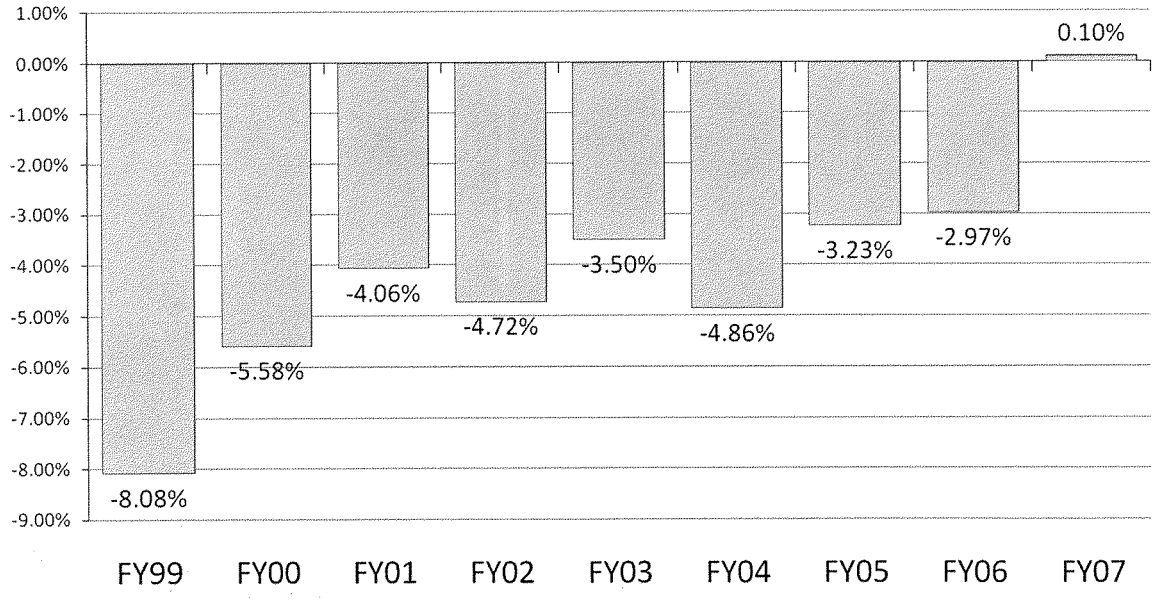
***General Acute Care Hospitals in Western (Highmark) Region**

Source: Hospital margins (1999-2006) from HAP analysis of PHC4 data, Hospital margins (2007) HAP Financial Survey

HAP

Patient Care Margins*

Southeastern Pennsylvania



***General Acute Care Hospitals in Southeast (Independence BC) Region**

Source: Hospital margins (1999-2006) from HAP analysis of PHC4 data, Hospital margins (2007) HAP Financial Survey

HAP

July 31, 2008

Testimony from WellNet Healthcare and related subsidiaries for the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Rights prepared for:

"TIME CHANGE --- Consolidation in The Pennsylvania Health Insurance Industry: The Right Prescription?"

My name is Harry Kovar & I am CEO of WellNet Healthcare.

The merger between IBC/Highmark makes sense from a business prospective with savings & synergy advantages to the Blues & hopefully to the Commonwealth of PA.

Everyone seems to be ignoring the potential damage this merger can have on competition that may have dire consequences in the future. Shouldn't we all err on the side of caution and think about specific conditions that the new Blues must agree upon for this committee to grant permission for this merger to happen & competition not only survive, but also flourish

WellNet has three recommendations, but before I offer them, I would like to go over two items that will help put these points into a better perspective.

1. WellNet has been doing business in the Commonwealth of PA for the past 13 years. We are flourishing in Southeastern PA & we are basically prohibited from entering into the Western market because IBC allows pharmacy carve-out & Highmark prohibits their clients from carving out this benefit.

2. About 4 years ago WellNet did a pre-sale analysis for a school system in Bucks County, PA. We showed a $750,000 savings if the School systems carved out & self-fund their pharmacy benefit. The day before this school system was to sign a contract with WellNet, Independence Blue Cross offered this school system a $750,000 reduction on their pharmacy benefits as well as lowered their medical cost 3% from the previous proposal.

   The following year, this school system gave WellNet the pharmacy contract because of the enormous increase they received from IBC & that year this school system saved over 1 million dollars with WellNet by self funding their Pharmacy benefits.

If carve-out Rx were not allowed, not only would this school system not have saved $1 million, but also all school systems in PA would be prevented from finding this alternative. If we pro-rate the $1 million savings on approximately 1,000 employees this school systems employs, there is $1000.00 savings per employee.

There are presently approx 147,000 employees in the PA school system & if we factor this number by $1000 there is a potential savings of $1.5 billion dollars that would not be available as an alternative for all school systems to consider.

We can then move to medium size businesses in PA there are over 4700 business in PA between 200-5000 employees totaling well over 2 million employees that would be prevented from accessing the alternative of self-funding their Rx program with a potential savings of at least $10 billion dollars.
So what I would propose for this committee to consider would be three conditions that the new Blues organization must agree upon if this committee would grant permission for them to merge. We know from our 13 years of experience that implementing these three will allow most of the advantages to dissipate. These three are

1. IBC and Highmark cannot be allowed to bundle pharmacy benefits within the medical benefit policy. Rx should be a stand alone service for a great many reasons which we just showed you as well as what will be shown shortly.

2. The same network discounts negotiated with hospitals, doctors and clinics should be offered to all Third Party Administrators and stand-alone networks at the same discounts offered to IBC/Highmark.

3. IBC/Highmark should be precluded from using their vast reserves from unfairly competing (buying business) by offering artificially low rates to drive competitors out of business

With the development of predictive modeling designed for the evaluation of pharmacy data can now allow businesses to have the necessary information to measure and manage medical benefit expenses as they would any other business expense. Companies can now identify, in-house, their problems, and develop solutions that fit their own needs instead of relying upon power point presentations put together by outside sources that give the appearances of best interest on behalf of plan sponsors.

This development will enhance choices companies will have to overcome problems. Companies can identify risk by identifying the diseases prevalent within their own population, and choose solutions from outside such as more competitive pharmacy benefit managers, disease management companies, self funding through third party administrators. Each choice will be eliminated should bundling be allowed.

WELLNET HEALTHCARE

The major diseases listed below have not only a cost or risk basis but on the other hand have a potential savings for companies if these disease are spotted early and/or solutions put in place to prevent or postpone catastrophic events, major savings can occur.

Prevalence and Medicines in Development for Selected Major Diseases in the United States

	Approximate Number of Medicines	
	Prevalence	Development
Alzheimer's Disease	4,000,000	26
Arthritis	40,000,000	28
Asthma	14,000,000	21
Cancer	8,000,000	492
Congestive Heart Failure	4,900,000	18
Coronary Heart Disease	13,900,000	42
Depression	17,600,000	26
Diabetes	15,700,000	25
Hypertensive Disease	50,000,000	11
Osteoporosis	10,000,000	14
Schizophrenia	1,500,000	16
Stroke	4,000,000	18

Source: Pharmaceutical Industry Profile 2000

Having aggregate information available at the fingertips of corporations that is HIPAA compliant, can develop a great deal of additional areas of cost savings. Incentives can be developed to encourage employees to utilize the most cost effective drugs and treatments, targeted information about specific diseases or conditions can be developed to educate the employee population and information about the best doctors, hospitals or clinics can be delivered specifically to employees that need this information. **All this comes from pharmacy data.**

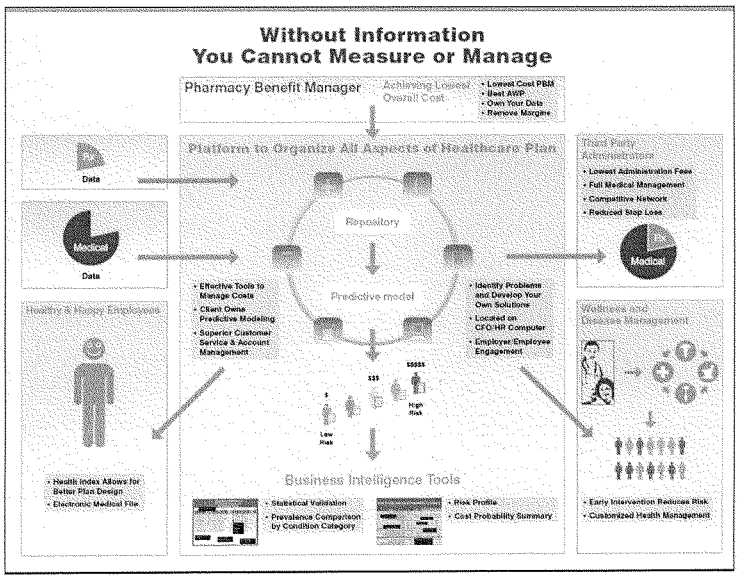
Our present healthcare system is broken or is on life support. The old traditional ways medical benefits in our country are adjudicated needs to be reviewed, changed or competition needs to be allowed to develop alternative solutions. It has been shown that over the past 30 years that we cannot rely only upon the healthcare carriers to find solutions that are in the best interest of their clients. These carriers have a first obligation to their stockholders and then their clients. Allowing more choices will allow more competition to address a redesign of health insurance benefits that take into consideration payment and performance improvement that will filter down to the bottom line of the client, not the insurance carrier. The first step is allowing competition to flourish & that can be accomplished by preventing the bundling of pharmacy benefits.

How the old traditional ways can be fixed:
Redesign of Health Insurance Benefits, Payment and Performance Improvement

- Prevention
- Management of Chronic Condition
- Care Coordination
- End of Life Care

WELLNET HEALTHCARE

Let me take a few minutes to make medical benefits less complicated so that we all can see the ramifications should this hearing allow IBC/Highmark to bundle pharmacy benefits within the medical benefit program. Without this understanding our recommendations will not seem that imperative. Outlined in graph below is the importance of having access to prescription drug data and the need for businesses to obtain it and use it proactively.



Before Keith Lemer's points are included on how and what benefits will be generated by the Commonwealth of PA by instituting requirements of not allowing Rx to be bundled inside a medical benefit plan, I would like to have 9 points entered into the record that will also add to Mr. Lemer's information.

Points to Consider

1. Employers who sponsor health plans need meaningful claims information to make more informed decisions about their plan funding options, including self-funding under ERISA.

2. Just as consumers need reliable product information when they are in the market for the items they buy, so too employers that sponsor health plans need meaningful claims information and loss experience data when making decisions about how to spend their valuable health care dollars.

3. Timely and detailed claims information facilitates cost- efficient management and administrative decisions by employers that sponsor group health plans. By analyzing what they are spending on health insurance and the benefits received by their employees, employers are able to identify the services and utilization trends that lead to high costs and help them to make better choices about how to fund their plans

4. Detailed claims data also helps employers to customize health plan design, including cost sharing, as well as to develop risk management strategies that improve plan performance.

5. Greater transparency of claims data also provides employers with important data to tailor valuable disease specific programs (i.e. diabetes, cardiovascular) for employees, including special wellness programs and disease specific information programs.

6. Ready access to timely claims information allows employers to make informed decisions about plan financing options, including self-funding the plan under ERISA. An insured employer interested in obtaining competitive bids on new coverage—whether from another insurer or to consider self-funding--needs access to timely health insurance plan information.

7. Employers considering the self-insurance option will usually purchase stop-loss insurance to cover their liability above specific/aggregate attachment points. The cost of stop-loss coverage will depend largely on plan claims and loss experience data. Ultimately, complete and detailed claims information is vital so that the stop-loss carrier can quote medical stop-loss on a currently fully insured plan.

8. Employer/plan sponsors seeking claims data have encountered resistance from many carriers who have raised concerns about possible exposure to liability for violation of privacy laws in connection with release of claims and loss data.

9. While Congress sought to protect the privacy of individual medical information in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 1/, the law provides federal standards and strict safeguards about the right of access to protected health information (PHI).

Under HIPAA, insurance carriers (often referred to as "issuers")

- Are permitted to release individual PHI to the employer/plan sponsor, either in its capacity as the Plan Administrator or as a fiduciary.
- ERISA defines "Plan Sponsor" as "the employer in the case of an employee benefit plan maintained by a single employer…"
- Generally, under the privacy rules, a health insurance issuer is allowed to disclose certain "summary health information" to the Plan Sponsor for the purpose of obtaining bids from other health insurers or health plans. This includes data relating to claims history and claims expenses, as well as total claims and total dollars paid. However, clearly, more than *summary health information* is needed by the employer in order to perform its duties as a plan fiduciary.
- **To obtain meaningful, competitive quotes from other insurers or to consider self-funding the plan, comprehensive claims data beyond *summary* data is needed by the employer. To facilitate access to more detailed information, HIPAA rules permit the release to the employer/plan sponsor of certain individual PHI data to allow the employer/plan sponsor to carry out its administrative functions. 4/ERISA defines "Administrator" as "the person specifically so designated by the terms of the plan…**
- The Plan Administrator is responsible for all operations and administration of the plans sum, rather than serve as a barrier to the release of important claims and loss information, HIPAA is intended to streamline the flow of information integral to operation of the health care system while protecting confidential health information from inappropriate access, disclosure and use.

Thank you for your time.

Pharmacy Benefits: Why is Rx information useful/powerful

My Name is Keith Lemer, and I am president of WellNet Healthcare and we provide stand-alone prescription drug benefits to hundreds of firms in Eastern Pennsylvania.

- In many cases, Rx benefits are very profitable when combined and sold with medical benefits (as Mr. Kovar has just shared with his school district example)
- In addition, prescription drug claims contain a wealth of information about current and future cost as well as risk
- **Having access to and analyzing Rx data to develop comprehensive disease and care management programs ultimately yields greater savings than simply paying medical and Rx claims.**
- Timely and detailed Rx claims information facilitates cost- efficient management and administrative decisions by employers that offer group health plans. By analyzing what they are spending on health insurance and the benefits received by their employees, employers are able to identify the services and utilization trends that lead to high costs and are able to make better choices about how to manage their plan.
- Currently, limited or no Rx data is available in the marketplace and even if data becomes available, there is no mechanism to interpret this data for useful purposes. What good is data if you're unable to use it ?
- **When pharmacy benefits are able to purchased as a stand-alone benefit, businesses are able to:**
    - Obtain better pricing
    - Customize plan designs
    - Manage their claims
    - Interpret their data and
    - Implement actionable strategies and powerful predictive modeling capabilities before problems get out of control

- Common sense says healthier employees cost less money to take care of, the sicker ones need the assistance, but you have to identify the unhealthy ones first and the clear-cut way is through the use of Rx data/information
- **The health care crisis can't be ignored.** Solutions are needed to improve access to low cost-high quality health care.
- In a recent study conducted by the "Business Group on Health," ***60% of employers believe their employees would change to better quality health care providers if they understood how quality varies and affects outcomes.***
- Many people in this room are familiar with Wellness and Disease Management programs which need to work hand in hand...all driven by real time Rx data.
- Preventing Diseases and effectively managing them once identified early on is the key to holding down health care costs. Again, the first place to begin is by understanding what is occurring in the prescription drug benefit portion.
- If employers offer benefits that help keep employees healthy, in the long run, the individual and the company win.
- **Isn't that what this merger is all about? Creating a winning combination?**

Allow the merger to proceed, but do so in a way that allows the business community and their employees to be the beneficiary of a well planned combination of two companies that truly are in the best interests of all those that live in the state of Pennsylvania.

Thank you.

Good afternoon. My name is Henry Cha, president of Healthcare Interactive Inc. Healthcare Interactive is a company that is commercializing healthcare software and other technologies for health-care administration and insurance.

The healthcare system is in a crisis mode due to snowballing costs that continue to rise in double digit numbers. During the last 10 years, information technology from an insurance perspective has helped to create "highly efficient pricing discipline" with "vigorous insurance underwriting cycle leading to wider margins," as reported by Dr. Ginsburg, presented to the Department of Justice in April of 2003 on Competition in Health Insurance. Simply, insurance carriers are very good in utilizing healthcare data to price their product well and have become even more profitable over the recent decade. Unfortunately this exercise of data analysis has created more profits for insurance, but not enough technology innovation to help reverse the rising trends of healthcare costs, and so, we continue to see double digit increases in all areas of healthcare today.

Currently in Pennsylvania, insurance is highly concentrated by 4 Blue Cross Blue Shield plans as reported by the Pennsylvania Medical Society, in a Federal Trade Commission Workshop on Health Care Competition Law and Policy on September 30, 2002:

- IBC owns 76% of Southeast Pennsylvania Health Insurer Market
- Highmark owns 74% of Western Pennsylvania
- Northeast Blue owns 63.4% of Northeast Pennsylvania
- Capital Blue Cross owns 53.4% of Central Pennsylvania

This high level of concentration has lead to the continued exits of carriers from unprofitable markets, creating less competition and higher barriers of entry. In the business of developing software and technology, certain business practices make it very difficult to penetrate the PA market. As described by Harry Kovar, because of the forced bundling of products in Highmark controlled areas, it is nearly impossible for other companies to compete with or introduce new products there. Where Healthcare Interactive have co-branded successfully with WellNet in the IBC market area that allows unbundled healthcare insurance products, we are an example of a company unable to sell our services in Highmark controlled areas. In fact, where Highmark controls most of Pittsburg, we do not have one single client in that area. Today, we have actually given up marketing in that area as the barrier of entry is too high.

When it comes to choice of insurance or choice of technologies from other companies, there is less in those areas. Although Highmark continues to use the argument that unbundling costs consumers more and creates higher cost factors, IBC does allow unbundled insurance services and still has significant market share in their target territory. The Highmark reason for bundling insurance products does not hold water, except to exclude competition. Ultimately, allowing these kinds of exclusionary business practices that limit consumer choice with forced bundling of insurance has been bad for Pennsylvania.

Allowing these practices and enabling the expansion in a merger between the two largest insurers of Pennsylvania without stipulations to promote competition will stifle innovation and technology development. It would be virtually impossible for technology companies like Healthcare Interactive to bring new products to these Pennsylvania markets.

Products that we are delivering like:

- Population–based segmentation based on demographic, behavioral and attitudinal factors generating new kinds of risk models – technologies not currently in use today
- A patient-centric healthcare social network interconnected seamlessly with the patient's utilization data, electronic medical records, schedules, chat, gaps in care, drug utilization data, predictive modeling, customer service, and other data points – giving consumers greater control of their health management
- A single platform containing patient healthcare touch points, administrative functions and communication tools - Healthcare Interactive's first-to-market, HIPAA compliant, healthcare social network will be launching next month in beta form

This next generation of products would be, in essence, unavailable to Pennsylvanians if the market is inhospitable to competition.

This committee must continue to support technology improvements in healthcare by creating a climate fostering competition. Improvements in information technology and reporting must not just improve carrier pricing and profitability, but can make major inroads in the development of relevant tools that identify member risk, improve member health, and reduce medical-benefit expenses for the people. These technologies must be continuously developed and supported through an efficient and competitive market, where the practice of bundling in highly consolidated areas must be disallowed. It is crucial that this committee stipulate that if Highmark and IBC merge, then the new entity must allow more options to the commonwealth of Pennsylvania with access to equivalent unbundled insurance products as part of all product offerings.

Finally, I would like to conclude with a statement by Joel Klein, Assistant Attorney General of the Antitrust Division for the US Department of Justice on June 22, 1999 before the House Judiciary Committee on the Quality Health-Care Coalition Act of 1999. He states:

"The better approach is to empower consumers by encouraging price competition, opening the flow of accurate, meaningful information to consumers, and ensuring effective antitrust enforcement both with regard to buyers (health insurance plans) and sellers (health care professionals) of provider services. Competitive issues are best dealt with in a manner which promotes competition, not retards competition,..."

Thank you.

My name is Judith Mueller, R.N, and I am president of WellNet Interactive, a wellness and health management organization that utilizes the powerful predictability of prescription drug data as core to the identification and management of people at current and future risk for costly medical expense. Thank you for allowing me an opportunity to submit my testimony to the committee.

We are all aware that the traditional method of controlling healthcare costs have not proven to be a long-term sustainable approach – this supported by mostly double digit medical trend increases year after year. National and northeast regional trend data tells us this, but more importantly, employers share this with us directly and we see it evidenced in the media almost every day. We also know that consumer interest in wellness and disease management is on the rise as employers look for solutions other than cost-shifting.

Innovative, data driven approaches, focusing on risk prediction and management instead of pure cost, as well as the development and implementation of strategies that keep people healthy and productive are, at least from my perspective, the antidote to the traditional approaches. Eliminating the opportunity to provide these types of non-traditional options by not allowing the unbundling of medical services does a tremendous disservice to the employer groups within the state of Pennsylvania – the very people who are asking for relief from the yearly premium increases typically expected as part of providing an employee benefit plan. We have developed an option that offers a different approach, which combines technology and member engagement that we feel will change the manner in which healthcare expense is managed.

In order to serve our PA clients and their plan participants, it is critical that our clients and we, in providing them health management services, have ready and easy access to group specific drug data, as well as other meaningful data sets (medical claims and HRAs) that we integrate into our proprietary predictive technology. Keeping medical and Rx services bundled will prevent access to the very core data set we need to serve our clients effectively and save them money on their healthcare expenses.

While we employ high tech data integration and analysis, it is the high touch our Care Managers provide to each member engaged in the program that ultimately reduces the costs to the plan and medical trends over time. We proactively outreach by phone vs. initial letter to individuals whose health conditions, singly or in combination, set the stage for future catastrophic expense to the Plan.

Our Care Manager develops a customized plan for each, in concert with the member and their physician providers. Since each member we engage has a unique set of healthcare issues as well as an individual learning style, we do not use a "one size fits all" program that targets diseases. Our interest is on the individual at risk and the potential for catastrophic expense to the Plan. Even when our health management program is implemented on a voluntary basis, which is the case for many of our clients, we are seeing a 50% + participation rate, defined in our program as actively engaged, talking and working with an RN Care Manager on a one to one basis. Resource intensive? Yes....Customized? Yes....Worth our investment in our clients and their members? Absolutely!

This level of participation has resulted in savings for our current clients that average a 5:1 ROI. Our objective is not to limit medical services, but rather to help each individual reach an optimal state of health thru access to and compliance with the appropriate medical care plan, education and support.

We serve multiple clients in the Philadelphia area because IBC has allowed unbundling of services. Because Rx data is available, I am able to develop competitive proposals for clients that offer a cost effective, customized, member focused health management option.

While we respect the merger, we are asking for contingencies that allow an even playing field so that competition exists and employers truly have options to choose from. Specifically, we want to be able to offer, on a state wide basis, our highly customizable services in the form of prescription drug management, wellness and health management, innovative business intelligence tools and healthcare technology. We ask your help in ensuring that the merger will be structured to allow for and promote healthy and equitable competition, which ultimately is a win-win for plan participants, employers and the healthcare companies that want to serve them.

Thank you.

57 Street Road / Southampton, PA 18966 / T 800-442-1101 / F 215-396-1764 / www.WellNetHealthcare.com

Contact Information:

Harry Kovar
Chief Executive Officer, WellNet Healthcare
hkovar@wellnethealthcare.com

Keith Lemer
President, WellNet Healthcare
klemer@wellnethealthcare.com

Henry Cha
President, Healthcare Interactive
Henry.cha@hciactive.com

Judith Mueller, R.N.
President, WellNet Interactive
jmueller@wellnethealthcare.com